



# This is Us!

NUJGE/40  
CONVENTION 2016

**No Health Without  
Mental Health**

The Way Forward



The National Union of Public and General Employees (NUPGE) represents 360,000 members who are employed in virtually every segment of our country's provincial public sector. We also have a growing membership among workers in the private sector.

Among the public sector members of our union are more than 100,000 women and men who work in Canada's health care system. They work ensuring that our health care facilities are clean and well maintained, providing diagnostic, therapeutic and pharmaceutical services and work as licensed practical and registered nurses.

Our members have a wealth of experience and knowledge and an important perspective on the current state of Canada's public health care system.

Furthermore, they are eminently qualified to offer recommendations for the future of our health care system and the negotiations for a new Health Accord.

We offer these comments and recommendations in the spirit of helping to improve and expand upon Canada's crown jewel of public programs—Medicare. Our members firmly believe our Medicare system is a triumph of Canadian values and economic wisdom.

Access to services and supports for Canadians with mental health problems is among the most serious social policy issues confronting the nation. Virtually every Canadian feels the effects of this problem.

In May of 2012, the Mental Health Commission of Canada (MHCC), as mandated by the federal government, released the long-awaited Mental Health Strategy for Canada. To date, no government in Canada has taken the necessary steps to fully implement the strategy.

Mental health has often been described as one of the "orphan children" of Canada's health care system. It is, for the most part, outside of mainstream health care. The result is a patchwork of programs and services. Government cutbacks and privatization have resulted in many Canadians with mental illnesses feeling abandoned, ignored, and swept under the carpet. There is a crisis in those services that provide support to people suffering with mental health problems. The services are underfunded and overwhelmed.

Without adequate treatment options, many people with mental health problems end up "falling through the cracks." All too often people with mental illnesses come into conflict with the law and find themselves in correctional facilities when appropriate treatment is what they need.

Inadequate access to mental health services means that more people must resort to relying on emergency rooms and hospitals—often when another form of intervention would be better. Not only is this often not in the best interests of the person experiencing a mental health problem, it also means that wait times for other patients become longer.

The National Mental Health Strategy, as drafted by the MHCC, must be implemented with particular emphasis on the creation of community services, staffed by mental health professionals, available at all hours—from coast to coast.

The federal government, working with the provinces, needs to step forward with funding targeted to expanding upon and creating new mental health programs across the country.

The National Union of Public and General Employees has a long history of advocating for increased supports for Canadians with mental health problems and addictions. Some examples of the work that we have done would include the following:

- May 2008—a comprehensive brief was submitted to the Mental Health Commission of Canada (MHCC) recommending: (1) a recognition that the public sector is the best vehicle for delivering quality mental health services; (2) the development of a mental health human resources strategy; (3) more financial support for community-based mental health services; (4) a strategy to ensure that people with mental health issues who can be treated in the health care system do not end up in prisons.
- October 2010—a Mental Health Issues Conference was held in Ottawa involving members from a broad range of sectors that work with people with mental health problems and addictions.
- February 2011—a series of days of action were held nationally focusing on the theme of “No more corporate tax cuts. We want more resources for mental health services.”
- January 2012—a meeting of Correctional Officers and Youth Facility Workers was held to coincide with a meeting of Justice Ministers in Charlottetown in order to highlight the situation of offenders with mental health problems and addictions.
- April 2015—NUPGE, working with the Public Services Foundation of Canada, issued a report, *Crisis in Correctional Services*, to raise awareness of the problems associated with an increase of inmates with mental health problems in overcrowded prisons.
- November 2015—a two-day roundtable session on Post-traumatic stress disorder (PTSD) was convened in Ottawa.

This paper is not intended as an exhaustive review of the literature on mental health problems and addictions in Canada. Instead, we are focusing on a few areas where our members have provided significant feedback to us when it comes to services and supports for people with mental health problems and addictions.

In particular, we will look at the:

- lack of access to services and need for a human resources strategy for all sectors;
- need for action on services for Indigenous communities;
- crisis of inmates with mental health problems and addictions in correctional facilities;

- impact on the workplace and rising issue of post-traumatic stress disorders;
- implementation of the MHCC’s Mental Health Strategy.

## 1 in 5 Canadians

The terms *mental illness* and *addiction* cover a diverse range of disorders that affect an individual’s mood, thinking, and behaviour. This can include more common disorders such as depression, anxiety disorders, schizophrenia, as well as substance abuse disorders and problem gambling. Symptoms vary from mild to severe, as does the impact on an individual’s ability to deal with their environment.

It is estimated that 1 in 5 Canadians will experience a mental health problem or addictions.<sup>1</sup> This means that approximately 7 million Canadians will likely experience a mental health problem or addictions in their lifetimes. In the overwhelming majority of cases, the problem will be of a mild nature.

The Centre for Addiction and Mental Health (CAMH) notes that,

- Of those who develop a mental health problem, about 70% will experience the onset during childhood or adolescence.
- Young people aged 15 to 24 are more likely to experience mental illness and/or substance abuse disorders than any other age group.
- Men have higher rates of addiction than women, while women have higher rates of mood and anxiety disorders.
- People with a mental illness are twice as likely to have a substance abuse problem compared to the general population. At least 20% of people with a mental illness have a co-occurring substance abuse problem. For people with schizophrenia, the number may be as high as 50%.
- Similarly, people with substance use problems are up to 3 times more likely to have a mental illness. More than 15% of people with a substance use problem have a co-occurring mental illness.
- Canadians in the lowest-income group are 3 to 4 times more likely than those in the highest-income group to report poor to fair mental health.
- Studies in various Canadian cities indicate that between 23% and 67% of homeless people report having a mental illness.<sup>2</sup>

Mood disorders are a common and frequent issue for many Canadians.

The annual prevalence of any mood disorder was 5.2%, and of any anxiety disorder 4.7%. Major depressive episode was the most prevalent mood and anxiety disorder (4.8%), followed by social phobia, panic disorder, mania, and agoraphobia. Among people with mood and anxiety disorders, 22.4% had 2 or more disorders.<sup>3</sup>

The societal and human costs of Canadians with mental health problems and addictions are staggering.

Mental illness remains the leading cause of disability in Canada, and people with mental illness and addictions are more likely to die prematurely than others.<sup>4</sup>

For some individuals, the problems associated with having a mental health problem or addictions can be overwhelming. The rates of death as a result of addiction or suicide are sobering. In 2011, 10.8 of every 100,000 Canadians died by suicide.<sup>5</sup> It is unacceptable that Canada does not do more to help people with these problems.

Unsurprisingly, there is also a strong relationship between mental health problems and addictions and an individual's physical health.

Mental health and physical health are fundamentally linked. People living with a serious mental illness are at higher risk of experiencing a wide range of chronic physical conditions. Conversely, people living with chronic physical health conditions experience depression and anxiety at twice the rate of the general population. Co-existing mental and physical conditions can diminish quality of life and lead to longer illness duration and worse health outcomes. This situation also generates economic costs to society due to lost work productivity and increased health service use.<sup>6</sup>

In a study looking at people between the ages of 18 and 65, who have one or more chronic health conditions, it was found that they were significantly more likely to report a major depressive episode than those who did not report chronic health conditions.<sup>7</sup>

A connection between mental health and physical health has been demonstrated for a number of chronic and acute health conditions.

- While 1 in 10 Americans, 18 and older, report depression, up to 33 % of heart attack patients develop some degree of depression.<sup>8</sup>
- 30% of people with diabetes demonstrate symptoms of depression, with 10% of them experiencing a major depression. It has been shown that a depressive mood leads to poorer physical and mental functioning, making it more difficult to manage diabetes.<sup>9</sup>

A significant part of the problem is the stigma associated with having a mental health problem or addictions. According to a 2008 survey conducted on behalf of the Canadian Medical Association

- Just 50% of Canadians would tell friends or co-workers that they have a family member with a mental illness, compared to 72% who would discuss a diagnosis of cancer, and 68% who would talk about a family member having diabetes.
- 42% of Canadians were unsure whether they would socialize with a friend who has a mental illness.
- 55% of Canadians said they would be unlikely to enter a spousal relationship with someone who has a mental illness.
- 46% of Canadians thought people use the term mental illness as an excuse for bad behaviour, and 27% said they would be fearful of being around someone who suffers from serious mental illness.

While impressive gains in social awareness of mental health problems and addictions have been made, we still have a long way to go. Social stigma against people with this range of disorders remains high.

## **Lack of treatment options and community supports**

Given the extent of the need for mental health and addiction services, the availability of services remains woefully inadequate.

For example, the Centre for Addiction and Mental Health in Toronto estimates that while “mental illness accounts for about 10% of the burden of disease in Ontario, it receives just 7% of health care dollars. Relative to this burden, mental health care in Ontario is underfunded by about \$1.5 billion.”<sup>10</sup>

This means that a considerable number of Canadians experiencing mental health problems are not getting the help they need. Research conducted by the MHCC

found that in 2012 at least 26.3% of Canadians, 15 years or older, who needed mental health care did not receive care.<sup>11</sup> It is unclear how many of these people tried to self-manage their condition for fear of the stigma attached to having a mental health problem. However, lack of available services must be a large contributor to the number of people having an unmet need.

One of the indicators of access to community-based mental health services is the length of hospital stays for people with a mental illness. Hospital stays of longer than 30 days suggest people cannot be released due to a lack of community supports. In 2012/2013, of the proportion of people hospitalized for a mental illness for 30 days or longer was 22.6%. This is, however, an improvement over the past but still indicates a serious lack of community supports.<sup>12</sup>

Another indicator of the lack of supports for people suffering a mental health crisis is the rate at which people are readmitted to hospital within 30 days of discharge. This can indicate a lack of community supports to assist the individual. In 2012/2013, more than one in ten people, 15 years and older, who were hospitalized for a mental illness were subsequently hospitalized three or more times in the same year.<sup>13</sup>

The lack of services for people with mental health problem or addictions has a substantial impact on the rest of the health care system. Research shows that, especially among young people, the rate at which they are visiting hospital emergency rooms (ERs) seeking mental health services is increasing:

In a study published this week in the *Canadian Journal of Psychiatry*, a research team led by Kurdyak found that among Ontario children and youth aged 10 to 24 with mental health issues, there was a 33% jump in the number of emergency department visits between 2006 and 2011.

Although hospitalizations overall were relatively rare, the rate of admissions also rose—by 53%, over the study period.<sup>14</sup>

Emergency rooms are not the best place for an individual experiencing an acute mental health problem or addiction. The reason for young people going to ERs to access mental health services is primarily due to the lack of access to mental health services in most communities.

Access to services is particularly lacking for children and youth. According to the Canadian Mental Health Association (CMHA), an “estimated 1.5 million Canadian children and youth (aged 0-24) are affected by mental illness and are not receiving access to appropriate supports, treatment or care.”<sup>15</sup>

A related issue to the lack of access is shortages in trained mental health professionals in all sectors. The CMHA conducted a research project on human resources strategy in mental health care, *Project IN4M: Integrating Needs for Mental Well-being for the MHCC*.

But human resource planning in Canadian health care has been flawed by our preoccupation with the supply side of the system and our tendency to think in terms of formal caregivers, particularly physicians and nurses. That’s led to poor decisions about the size and focus of education programs.

Project IN4M is a three-phase research project, jointly funded by Health Canada and the Mental Health Commission. It’s overall goal is to improve the accessibility of high-quality mental-health services “through needs-based predictive modelling of health, social, education, criminal justice and private sector human resources—including informal caregivers.”<sup>16</sup>

The lack of training in addressing mental health problems and addictions is particularly acute in areas such as corrections and criminal justice, emergency services, and community services.

## **Need for mental health and addictions supports for Indigenous peoples in Canada**

The historical and ongoing treatment of Canada’s Indigenous peoples continues to be a national shame. The process of colonization and attempts to force assimilation of Inuit, First Nations, or Métis peoples have left a serious mark on all of these communities. It is time that Canada addresses the historical wrongs that have been committed against Indigenous peoples in Canada.

This is particularly evident when looking at issues of mental health and addictions in Canada.

On 17 April 2013, the remote, fly-in community of Neskantaga First Nation in Northern Ontario declared a state of emergency following two suicides in less than a week and 20 suicide attempts over the previous year. This situation is not unique. First Nations and Inuit communities experience mental health problems and their consequences—such as depression, anxiety and suicide—at significantly higher rates than the general population, and young people are the most dramatically affected. The disproportionately high prevalence of mental health problems in Aboriginal communities can be linked, in part, to a history of cultural disruption, oppression and marginalization.<sup>17</sup>

When looking at mental health issues among Indigenous peoples context, is important to consider. For example, the impact of the residential school system on Indigenous communities and within specific families cannot be understated.

Residential schools operated in Canada from the late 1800s through to the late 1960s, though a few remained in operation until the 1990s. During this period, more than 150,000 First Nations, Inuit and Métis children were taken to residential schools and isolated from their families, with the purpose of assimilating them into the dominant culture. The resulting loss of culture and language meant that many children were unable to participate in traditional activities, finding themselves “in a marginalized position as neither fully Aboriginal nor part of the ‘mainstream.’” Moreover, many children in the residential school system were victims of emotional, physical and sexual abuse. These children often internalized these abuses, repeating the behaviour with other community members upon their return to their communities.<sup>18</sup>

It is essential to understand how socio-economic status and related factors lead to serious health inequities (both physical and mental) for Aboriginal peoples and their communities in Canada. The fact is, many Aboriginal peoples and communities would be ranked as being among the lowest strata for almost all the factors considered as social determinants of health.

However, it would be a mistake to point only to the social determinants of health when discussing these health inequities. It is essential that we also consider the harms wrought by centuries of colonization and racism. While Aboriginal people in

Canada can and do share in experiences of racism similar to other racialized communities, the impact of colonization must also be factored into the discussion.

The mental health problem among Indigenous communities that Canadians are most aware of is likely the incidence of suicide. While this is not a problem faced by all communities, it does present a considerable challenge.

First Nations youth commit suicide about five to six times more often than non-Aboriginal youth. The suicide rates for Inuit are among the highest in the world, at 11 times the national average, and for young Inuit men the rates are 28 times higher. Less is known about suicide rates among Métis.<sup>19</sup>

Again this is not uniform for all Indigenous communities in Canada. There are those communities for which there are virtually no suicides, while others experience rates at nearly 800 times the national average.<sup>20</sup>

Perhaps the most important indicator of health issues among First Nations communities is the perception that residents themselves have of their community. According to the 2008/2010 First Nations Regional Health Survey (RHS):

- A high prevalence of First Nations adults observed challenges within their community. The most commonly identified were alcohol and drug abuse (82.6%), housing (70.7%), and employment/number of jobs (65.9%).
- Of those who identified these community challenges, two-thirds (or more) of First Nations adults perceived no improvement or worsening of all 10 possible community challenges listed (i.e., education and training, alcohol and drug abuse, housing, culture, natural environment/resources, health, funding, control over decisions, gang activity, employment/number of jobs).<sup>21</sup>

Among First Nations communities the incidence of psychological distress is higher than in the general population.

Approximately half (50.7%) of all First Nations adults reported either moderate or high levels of psychological distress, compared to only one-in-three adults (33.5%) in the general Canadian population.<sup>22</sup>

The higher incidence of psychological distress suggests that there will be a higher incidence of psychological disorders among these communities.

Though the RHS did not determine the prevalence of psychological disorders on reserve, the elevated rate of psychological distress was suggestive of a corresponding elevated rate of psychological disorders in First Nations communities.<sup>23</sup>

Access to all health services, never mind mental health and addictions supports, is a challenge for almost all First Nations communities. This is often compounded by the lack of services delivered in a culturally sensitive manner.

First Nations people and Inuit, particularly those living off reserve or outside their traditional territories, can face challenges in accessing comprehensive and culturally responsive health services. Northern and remote communities experience additional challenges related to the high cost of delivery, shortages in health care providers, limited offering of health services (i.e., typically only basic health services) and lack of appropriate health infrastructure.<sup>24</sup>

Many of these problems are a result of the lack of coordination between different levels of government and agencies. The federal government must step forward to address these concerns.

### **Canada's prisons: The mental health service of last resort**

Sadly, the best indicator of the lack of mental health and addictions services in Canada is to be found in our criminal justice system. While the overwhelming majority of people with mental health problems never come into conflict with the justice system, there are a growing number who do and who wind up in our correctional facilities.

Psychiatric institutions have been closing over the years, and the mentally ill...have now found that the correctional system has become the institution of last resort.<sup>25</sup>

The 2008 report by the Vancouver Police Department, *Lost in Transition: How a Lack of Capacity in the Mental Health System is Failing Vancouver's Mentally Ill and Draining Police Resources*, showed the extent to which people with mental health problems

are criminalized.<sup>26</sup> The study showed the growing problem of people with mental illnesses who, unable to find adequate mental health services, were often ending up in the criminal justice system.

In their 2010 follow-up, the Vancouver police found that they continued seeing an increase in the amount of time that officers dealt with people with mental health or addictions problems. It was estimated that mental illness contributes to 21% of all incidents handled by their officers, and 25% of the total time spent on calls where a report is written.<sup>27</sup>

It is obvious that incarceration is the worst possible way to deal with an individual with a mental health problem.

Jailing people who need support and treatment runs so contrary to Canadian human rights values that most Canadians would be amazed to learn that it happens as routinely as it does.<sup>28</sup>

Corrections Services Canada (CSC) data shows that the proportion of federal offenders with mental health needs, identified at intake, has doubled between 1997 and 2008. The Correctional Investigator's breakdown of those figures indicates

- 13% of male inmates and 29% of female inmates were identified at admission as presenting mental health problems.
- 30.1% of women offenders compared to 14.5% of male offenders had previously been hospitalized for psychiatric reasons.
- Offenders diagnosed with a mental illness are typically afflicted by more than one disorder, often a substance abuse problem, which affects 4 out of 5 offenders in federal custody.
- 50% of federally sentenced women self-report histories of self-harm, over half identify a current or previous addiction to drugs, 85% report a history of physical abuse and 68% experienced sexual abuse at some point in their lives.<sup>29</sup>

Research has also indicated that more female inmates have had previous hospitalizations for mental illness (30.1%) than their male counterparts (14.5%).

There is far less known about inmates with mental health problems in the provincial correctional system than in the federal. This is concerning as the provincial systems likely house significantly higher numbers of inmates struggling with mental health or addictions problems.

In order to accurately identify who is in need of assistance and what type of services that they need, effective screening and assessment practices are required. While the CSC has recently implemented improved admissions screening, the Schizophrenia Society of Ontario (2012) found that screening practices in provincial and federal institutions are generally inadequate and inconsistent.<sup>30</sup>

Ontario's Ministry of Community Safety and Correctional Services (MCSCS) reported that 15% of inmates required a clinical intervention for mental illness in 2008. Mental illness is more prevalent in the remand population, where mental health alerts have increased by 44.1% in the last decade.<sup>31</sup> In British Columbia, the Ministry of Justice estimates that more than half of offenders (56%) in the province's corrections system have a substance abuse and/or mental health problem.<sup>32</sup>

Provincial justice systems show considerable variation in how they respond to offenders with mental health or addictions problems. There are an increasing number of mental health courts across the country attempting to prevent this population from entering the correctional system. Some provinces have created dedicated units and facilities to respond to these inmates.

However, the demand for programs and treatment is considerably greater than what is available. Increasingly, there have been reports in the media about how segregation (solitary confinement) or lockdown is used to either control, or protect, inmates with mental health or addictions problems. Segregation, for the overwhelming majority of inmates with these problems, often only makes the mental health problems worse.

There are also reports of how existing mental health units are not being used, or being under-used, as a result of lack of staffing or as a cost-saving measure. In their report, *Crisis in Correctional Services*, the Public Services Foundation of Canada states that the Toronto South Detention Centre has a dedicated mental health unit that administration had yet to open.<sup>33</sup>

In November 2008, a Federal-Provincial-Territorial Working Group on Mental Health (FPT WGMH) was tasked, in consultation with the Mental Health Commission of Canada (MHCC), to develop a *Mental Health Strategy for Corrections in Canada*.<sup>34</sup> It is hoped that this will lead to reforms for Canadian correctional policy and practice.

It is absolutely clear that more effort must be made to end using the police and jails as the default treatment option for people with mental illnesses. There needs to be action at all levels to address the deficiencies in the delivery of mental health services for all Canadians. This will help to ensure that these vulnerable Canadians get the treatment and support they need in the community rather than being confined in correctional facilities.

## **Mental health and the workplace**

The majority of Canadians spend a large proportion of their life at work. More than 72% of Canadians, between 15 to 64 years of age, have a paid job with there being a gender split of 75% of men having paid employment as compared to 70% of women.<sup>35</sup> Most people spend approximately 60% of their waking hours at work.

While most individuals with a mental health problem or addictions manage to maintain employment, it is the case that those with a mental illness are less likely to be employed. The unemployment rates for those with severe mental illnesses are as high as 70% to 90%.

Mild depression, depressive episodes, and anxiety are among the most prevalent mental health issues found in the workplace.

Common mental health problems such as depression or anxiety have significant prevalence in the workforce. Thirteen percent of workers report a troublesome level of depression at any particular time and eighteen percent of the working population report having missed work or cut back on workload because of depressive symptoms.<sup>36</sup>

A 2007 study by Statistics Canada found that

Workers who had experienced depression were more likely than those who had no history of depression to report several specific forms of work impairment: reduced activities due to a long-term health condition, at least one mental health disability day in the past two weeks, and absence from work in the past week.

Compared with workers with no history of depression, those who had had an episode in the previous year were almost three times as likely to report reduced work activities because of a long-term health condition (29% versus

10%). Even workers who had not experienced depression in the previous year but who had a lifetime history of depression were at increased risk of reducing their work activities (16%).<sup>37</sup>

It should be said that it is likely that those workers with a history of depression deliberately reduce their activities as a way to minimize the risk of another depressive episode.

The Statistics Canada study reported that depression was strongly related to mental health disability days.

13% of workers who had experienced depression in the previous year reported at least one day in the past two weeks when, because of emotional or mental health or the use of alcohol or drugs, they had had to stay in bed, cut down on normal activities, or their daily activities took extra effort. By contrast, only 1% of workers with no history of depression reported a mental health disability day.

Work absences were far more common among people who had experienced depression in the previous year than among those with no history of depression. While 16% of workers reporting a recent episode had been absent the past week, the figure was 7% for those who had never had a depressive episode.<sup>38</sup>

When considering all mental health problems and illnesses, it is estimated that they account for nearly 30% of short- and long-term disability claims in Canada.<sup>39</sup> In any given week, at least 500,000 employed Canadians are unable to work due to mental health problems. This includes approximately 355,000 disability cases due to mental health issues and/or behavioural disorders and a further 175,000 full-time workers absent from work due to mental illness.<sup>40</sup>

However, Statistics Canada found that lost productivity from presenteeism, working while ill, was at least 7.5 times greater than productivity loss from absenteeism and that it is estimated that presenteeism costs Canadian businesses \$15 to \$25 billion per year.

The manner in which mental health problems and addictions can have an impact in the workplace, other than in lost hours, is easy to understand.

Mental health problems are associated with considerable individual suffering, functional impairment and productivity loss, with corresponding costs to the employer.<sup>41</sup>

Workplace stress appears to be a problem for many Canadians. In 2011/2012, 28.4% of working Canadians (aged 15 to 75 years) reported that most days at work were *quite a bit stressful* or *extremely stressful*.<sup>42</sup>

The presence of a worker with a mental health or addiction problem in the workplace can have a significant effect on co-workers. For example, a 2012 employee survey found that 12.65% of the participants reported exposure to a co-worker who used or was impaired by an illicit drug during the workday.<sup>43</sup>

Overall, in addition to the impact of mental health and addictions issues on individuals and their families, the cost of these issues in the workplace is staggering. A 2011 study by the MHCC predicts that, if not addressed, the impact of mental health problems (due to absenteeism, presenteeism and turnover) will cost Canadian businesses \$198 billion in lost productivity over the next 30 years.<sup>44</sup>

This presents a powerful value-based and economic argument for the need for workplace measures to address mental health problems and addictions. However, there is also a growing body of case law and regulatory requirements that mandate employers to implement measures to protect and respond to the psychological health and safety of their employees.

It is worth quoting somewhat at length from the conclusion of Martin Shain's report for the MHCC, *Tracking the Perfect Legal Storm*.

A perfect legal storm is brewing in the area of mental health protection at work.

This storm brings with it a rising tide of liability for employers in connection with failure to provide or maintain a psychologically safe workplace. The duty to provide and maintain a psychologically safe workplace is expressed and acted upon in different ways across the country and in different branches of the law, but the unmistakable common thread is the increasing insistence of judges, arbitrators and commissioners upon more civil and respectful behaviour in the workplace and avoidance of conduct that a reasonable person should foresee as leading to mental injury.

Legal proscriptions are also being supplemented by legal prescriptions in that arbitrators, commissioners and even judges are becoming more proactive and directive in their decisions concerning the manner in which management rights should be exercised if they are not to violate the rights of employees to a psychologically safe system of work.

It appears that, although there are limits to the duty to provide a psychologically safe workplace, the law is reaching further and further into the control rooms of both private and public organizations, large and small.<sup>45</sup>

In response to the growing importance of the issue of workplace measures to prevent and support workers with mental health and addictions issues, the MHCC worked with the Canadian Standards Association (CSA Group) and the Bureau de normalisation du Québec to develop the *National Standard of Canada for Psychological Health and Safety in the Workplace* (Standard).<sup>46</sup>

The Standard is a “voluntary set of guidelines, tools and resources focused on promoting employees’ psychological health and preventing psychological harm due to workplace factors.”<sup>47</sup>

Launched in January 2013, the Standard has received considerable attention across the country. There is a three-year Case Study Research Project in place that started in 2014. The case study will follow implementation of the Standard in over 40 organizations to better understand its impact.

## Post-traumatic Stress Disorder

While the impact on the workplace of people with mental health or addictions problems in the workplace is considerable there are also those instances where events at work can inflict a mental injury on the worker. Perhaps the most extreme example of this results in what is referred to as post-traumatic stress disorders (PTSD).

The prevalence of PTSD among Canadians is approximately 8% of the population,<sup>48</sup> though some recent research places the number as high as 9.2%.<sup>49</sup> However, the incidence of PTSD is much higher among first responders and military personnel.

According to the Tema Conter Memorial Trust, an advocacy organization for first responders and military personnel with PTSD, the prevalence of PTSD within Emergency Services is between 16% to 24%.

According to the Tema Conter organization, in February 2016 the rates of PTSD in the various services in Canada were:

- Corrections: 25.6%
- Paramedics: 25.5%
- Firefighters: 17.3%
- Police Officers: 7.6%
- Canadian Military: 8%<sup>50</sup>

Among first responders, the impact of PTSD can be devastating and even fatal. The number of first responders and military personnel who commit suicide has become a national issue.

- As of April 2016, 16 first responders and 5 military members have died by suicide.
- In 2015, 39 first responders and 12 military members died by suicide.
- Between April 29 and December 31, 2014, 27 first responders died by suicide.
- In 2014, there were 19 military personnel who died by suicide.<sup>51</sup>

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, and 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. Post-traumatic stress disorder is often also referred to as an 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 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.<sup>52</sup> 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).<sup>53</sup>

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.<sup>54</sup>

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.”<sup>55</sup>

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.

Provincial legislation, for the most part, has lagged behind public awareness or research on PTSD. There is considerable variation among the provinces with regard to how Workers' Compensation treats workers who have PTSD.

Perhaps most notable are the differences between provinces 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.

One of the best approaches to supporting workers with PTSD is referred to as *presumption*, where it is assumed that the PTSD claims of workers 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 Ontario and Alberta, presumption is restricted to first responders—emergency medical technicians, firefighters, peace officers and police officers. New legislation in Manitoba extends presumption to cover all workers in the province.

The new legislation in Manitoba took effect on January 1, 2016, and is applicable to all workers covered by the *Workers Compensation Act*. Under the Manitoba legislation, PTSD

- is considered an occupational illness unless the contrary is proven by the WCB;
- can be caused by a single event or a series of events;
- can be diagnosed by a physician or a psychologist.<sup>56</sup>

While this is considered a positive step in the province, it does appear that employers have responded by increasing the number of challenges to PTSD claims. As in Alberta, it is expected that this initial increase will level off and, perhaps, decline.

## **A mental health strategy for Canada**

It was for some of these reasons that the Mental Health Commission of Canada (MHCC) was created by the federal government in March 2007. The MHCC's release in 2012 of a Mental Health Strategy for Canada marked a significant step forward.

The Mental Health Strategy focused on 6 strategic directions, quoted here from page 8 of the strategy:

1. Promote mental health across the lifespan in homes, schools and workplaces, and prevent mental illness and suicide wherever possible.
2. Foster recovery and well-being for people of all ages living with mental health problems and illnesses, and uphold their rights.
3. Provide access to the right combination of services, treatments and supports, when and where people need them.

4. Reduce disparities in risk factors and access to mental health services, and strengthen the response to the needs of diverse communities and Northerners.
5. Work with First Nations, Inuit and Métis to address their mental health needs, acknowledging their distinct circumstances, rights and cultures.
6. Mobilize leadership, improve knowledge and foster collaboration at all levels.<sup>57</sup>

The strategy is wide-reaching document that not only targets change in the health care system but within government, workplaces, non-governmental organizations, and the media. The following list, quoted from the Strategy, calls for:

- people living with mental health problems and illnesses and their families to become more engaged in the planning, organization, delivery and evaluation of mental health services, treatments and supports;
- mental health service providers to work with planners, funders, and users of the system to examine what changes are required in the way that they work in order to create a system that is better integrated around people's needs and fosters recovery;
- governments to take a comprehensive approach to addressing mental health needs, to re-focus spending on improving outcomes, and to correct years of underfunding of mental health;
- senior executives in both the public and private sectors to create workplaces that are as mentally healthy as possible, and to actively support the broader movement for improved mental health;
- all Canadians to promote mental health in everyday settings and reduce stigma by recognizing how much we all have in common—there is no 'us' and 'them' when it comes to mental health and well-being.<sup>58</sup>

Acknowledging the ongoing underfunding of the mental health system, the strategy proposes that funding shortfalls be addressed by

- Increase the proportion of health spending that is devoted to mental health from seven to nine% over 10 years;
- Increase the proportion of social spending that is devoted to mental health by two percentage points from current levels;
- Identify current mental health spending that should be re-allocated to improve efficiency and health outcomes, and
- Engage the private and philanthropic sectors in contributing resources to mental health.<sup>59</sup>

The initial response to the release of the mental health strategy was one of great optimism. It was accompanied by a surge in public support for action on mental health and addictions issues. Sadly, there remains a long way to go towards fully implementing the Mental Health Strategy for Canada.

There has been considerable work done to reduce the stigma against people with mental health problems and addictions. Widespread media campaigns, some funded by corporations, have helped further a much-needed public dialogue on the issues.

However, far less appears to have been done by governments in increasing the funding required to provide necessary services. Indeed, many would be hard pressed to see how the current state of affairs is any different than what existed prior to the release of the strategy.

### **The National Union of Public and General Employees, and its Components, will**

- Lobby federal and provincial governments for the implementation of the Mental Health Strategy for Canada.
- Continue to push for a human resources strategy to provide mental health training for workers in a wide range of sectors.
- Continue to raise awareness of the growing crisis of people with mental health problems and addictions in the criminal justice system.
- Lobby provincial governments for the introduction of legislation that will presume for workers who develop post-traumatic stress disorders that they are a result of workplace stressors unless proven otherwise.
- Develop materials to assist in bargaining to protect workers who develop PTSD.
- Continue to collaborate on health and safety measures to prevent or respond to mental injury in the workplace.

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