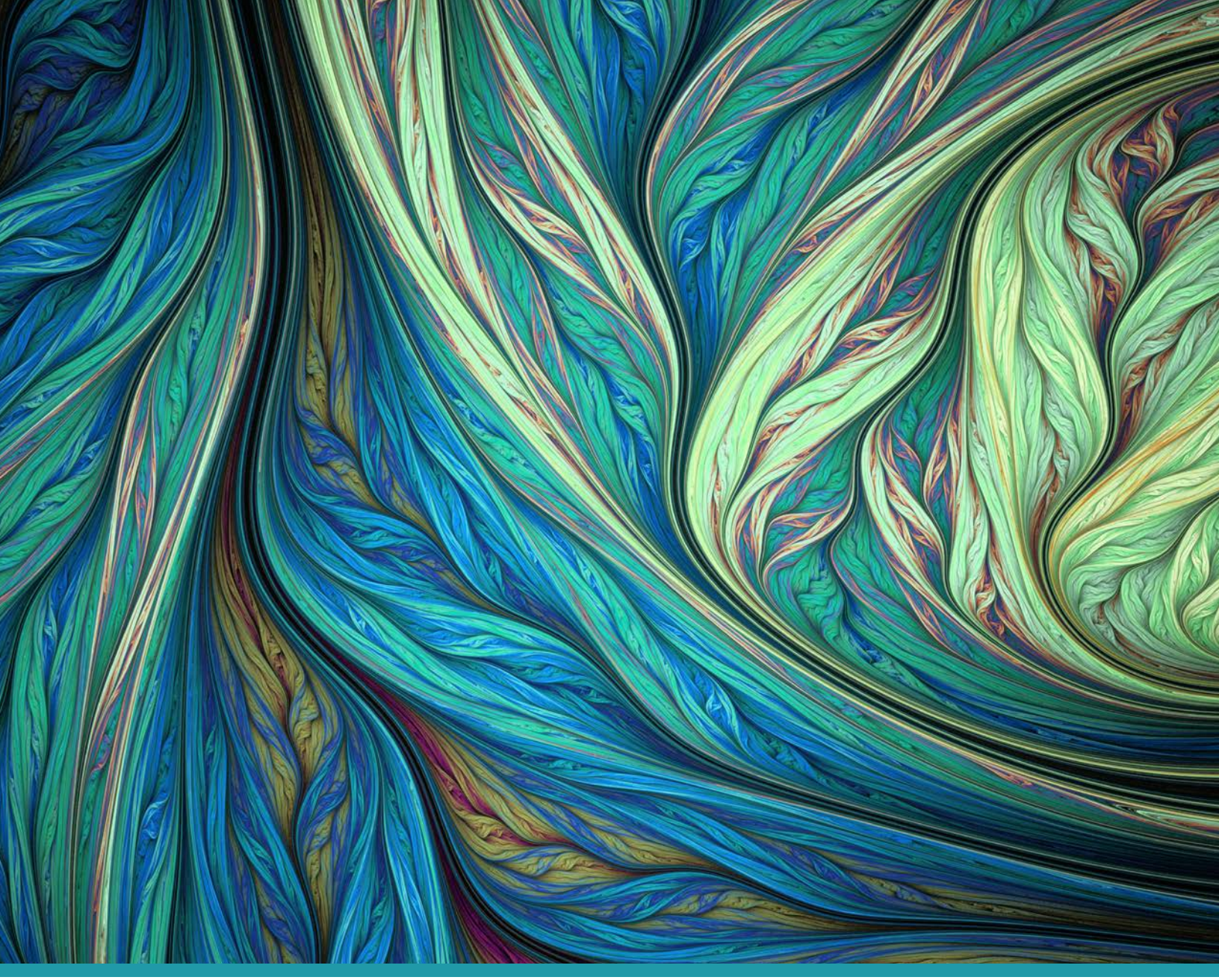

FEDERAL FRAMEWORK ON POSTTRAUMATIC STRESS DISORDER

RECOGNITION, COLLABORATION AND SUPPORT

Government of Canada
Gouvernement du Canada

Canada

TO PROMOTE AND PROTECT THE HEALTH OF CANADIANS THROUGH LEADERSHIP, PARTNERSHIP, INNOVATION AND ACTION IN PUBLIC HEALTH.

—Public Health Agency of Canada

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FEDERAL FRAMEWORK ON POSTTRAUMATIC STRESS DISORDER

RECOGNITION, COLLABORATION AND SUPPORT

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ABBREVIATIONS

CAF	Canadian Armed Forces
CCG	Canadian Coast Guard
CFNU	Canadian Federation of Nurses Union
CIHR	Canadian Institutes of Health Research
CIMVHR	Canadian Institute for Military and Veteran Health Research
CIPSRT	Canadian Institute for Public Safety Research and Treatment
CISM	Critical Incident Stress Management
CSIS	Canadian Security Intelligence Service
DFO	Department of Fisheries and Oceans
DND	Department of National Defence
EAP	Employee assistance programs
EAS	Employee Assistance Services
LGBTQ2	Lesbian, Gay, Bisexual, Transgender, Queer, Two-Spirit
MHCC	Mental Health Commission of Canada
MHFA	Mental Health First Aid
OSI	Operational stress injury
OSISS	Operational Stress Injury Social Support
OTSSC	Operational Trauma and Stress Support Centres
PHAC	Public Health Agency of Canada
PSC	Public Safety Canada
PTSD	Posttraumatic Stress Disorder
PTSI	Posttraumatic Stress Injuries
RCMP	Royal Canadian Mounted Police
VAC	Veterans Affairs Canada

ACKNOWLEDGEMENTS

The *Federal Framework on Posttraumatic Stress Disorder (PTSD)*[a] was developed in recognition of those who live with PTSD, their families and support networks and those who are at risk of developing PTSD.

We are deeply grateful for the impassioned involvement of the many partners and stakeholders who informed the development of the Framework through: the National Conference on PTSD in April 2019; our official governance structure; and, the many conversations that have taken place since the *Federal Framework on PTSD Act* received Royal Assent in June of 2018. These partners and stakeholders include federal government departments, non-governmental organizations, provincial and territorial groups and governments, Indigenous organizations and other experts reflecting the diversity of Canada's geographical and social communities.

Many who contributed to the Framework have experienced PTSD firsthand. We acknowledge their lived and professional expertise and are grateful for their candour in sharing their insights.

Finally, we acknowledge that symptoms of PTSD are not always recognized by individuals, family members, co-workers, support networks, health care providers, or employers. Stigma and other barriers to timely diagnosis, care and treatment remain. The Framework, which would not have been possible without our partners and stakeholders, will help us work together to address these challenges.

If you or someone you know needs mental health support, you are not alone. Please visit the Government of Canada Mental Health Support web page at: https://www.canada.ca/en/public-health/services/mental-health-services/mental-health-get-help.html for more information.

[a] While the spelling in the Act has a hyphen (i.e., post-traumatic), the spelling in the Diagnostic and Statistical Manual of Mental Disorders (DSM) does not. For the purposes of this Framework, the DSM spelling (i.e., posttraumatic) will be used, except when referencing the Act specifically.

MINISTER'S MESSAGE

I am privileged to share Canada's first *Federal Framework on Posttraumatic Stress Disorder (PTSD)*. Many Canadians may develop PTSD during their lifetimes in the wake of exposure to trauma. The Framework recognizes that a great number face increased risks because of the unique nature and demands of their occupation.

The release of the Framework marks an important milestone in our efforts to better recognize, collaborate with and support those impacted by PTSD. The content was informed by a national conference on PTSD held in April 2019, and further developed with the direct involvement of a diverse group of stakeholders and partners, including those with lived experience. We heard many inspiring stories of courage and healing. At the same time, we heard about significant gaps and lack of access to PTSD supports across Canada. We are hopeful that many of the relationships we have built during the development of the Framework will continue to grow as we move forward to address these gaps.

While important advances have been made in a relatively short period, our work must continue. The call to action from our partners and stakeholders was evident: we must end the stigma, improve our understanding of PTSD, promote evidence-based practices for its treatment and management, increase awareness and learn from each other by working collaboratively.

As we move forward, the Framework can guide our collective efforts. It encourages us to work together to advance our knowledge of PTSD, while building on many important initiatives and investments that are already in place.

Through the actions outlined in the Framework, we hope to make a meaningful difference in the lives of those affected by PTSD. I sincerely thank all those who contributed to the Framework's development and have helped us get to this point. I am confident that with the help of our partners and stakeholders, we can achieve the vision set out in this document, *"A Canada where people living with PTSD, those close to them, and those at risk of developing PTSD, are recognized and supported along their path toward healing, resilience, and thriving."*

The Honourable Patty Hajdu, P.C., M.P.
Minister of Health

QUOTES

> The Government of Canada is providing national leadership to help address the mental health needs of Canadians who are impacted by PTSD and post-traumatic stress injuries (PTSI). Public safety personnel put their lives on the line every day, which can put them at risk of developing PTSI. That is why last April we released a national action plan on PTSI for all public safety personnel across Canada. I am pleased to see the Federal Framework on PTSD building on this work and the work of others."

The Honourable Bill Blair
Minister of Public Safety and Emergency Preparedness

> While we have come a long way in our understanding of the invisible wounds that Canada's Veterans may be struggling with, we know more must be done. With this Framework, our government pledges to support effective programs and treatment for all these brave Canadians. I congratulate everyone who contributed to the creation of this Federal Framework, and I thank all the brave Canadians it will serve for their sacrifices."

The Honourable Lawrence MacAulay
Minister of Veterans Affairs

> Posttraumatic Stress Disorder (PTSD) can have a profound impact on those faced with it and on their families, friends and colleagues. The Department of National Defence proudly supports the Federal Framework on PTSD. Through education, early intervention and world-class treatment we will make sure the women and men of the Canadian Armed Forces receive the highest standard of health care and support."

The Honourable Harjit Sajjan
Minister of National Defence

EXECUTIVE SUMMARY

The *Federal Framework on Post-Traumatic Stress Disorder Act* (the Act) became law on June 21, 2018, after receiving all-party support in Parliament. The Act underscores the diversity of occupational groups at higher risk of developing PTSD and the need for a coordinated approach to support those affected. As such, the Act called for the development of a comprehensive federal framework, informed by a national conference. The Public Health Agency of Canada (PHAC) was mandated to lead this work.

The National Conference on PTSD was held on April 9–10th, 2019, in Ottawa. Over 200 conference participants representing a wide-range of partners and stakeholders, including individuals with lived-experience, provided meaningful and productive dialogue on issues pertaining to:

- improved tracking of the rate of PTSD and its associated economic and social costs;
- the promotion of guidelines and sharing of best practices related to the diagnosis, treatment and management of PTSD; and,
- the creation and distribution of educational materials related to PTSD to increase national awareness and enhance diagnosis, treatment and management.

While the National Conference was the main consultation mechanism, engagement with partners and stakeholders continued throughout the development of the Framework. The entirety of engagement activities, as well as the requirements stated in the legislation, provided the foundation for the Framework.

Part I provides background and context, defining PTSD and providing information on occupations and populations at higher risk of developing PTSD. It describes key organizational roles and responsibilities for PTSD in Canada and summarizes the engagement that took place to inform this Framework, including highlights from the National Conference.

Part II, the heart of the Framework, sets out the scope, purpose, vision and guiding principles, including the importance of complementing existing initiatives and leveraging partnerships in addressing PTSD. This section also provides information on the drivers and considerations for each of the priority areas set out in the legislation, as well as federal actions setting the path to progress in each of them. Finally, an additional priority area highlighting the importance of collaboration among partners and stakeholders, which was not specifically articulated in the Act, is included in this section.

Part III outlines next steps in implementation, including the role of the PTSD Secretariat at PHAC. It reiterates the need for collaboration with all partners and stakeholders in advancing the priority areas, and encourages all parties to build on the vision and guiding principles of the Framework in advancing their own initiatives in the area of PTSD. It concludes by stating that the Framework is intended to encourage continuous open dialogue and that as we learn more about PTSD, the actions under this Framework will undoubtedly continue to evolve.

Additional information is provided in the Appendices. This section includes an overview of a number of non-occupation related populations at increased risk of developing PTSD, a high level synopsis of current PTSD initiatives in Canada, and a Glossary outlining definitions related to PTSD and trauma developed by the Canadian Institute for Public Safety Research and Treatment (CIPSRT) in collaboration with a number of experts.

As mandated by the Act, PHAC will complete a review of the effectiveness of the Framework within five years from the date of this Framework's publication.

PART I
CONTEXT AND BACKGROUND

INTRODUCTION

Posttraumatic Stress Disorder (PTSD) has an enormous impact on individuals, families, caregivers, and workplaces. All Canadians can be at risk for PTSD following exposure to trauma, but some populations are at greater risk because of the type of job they do. That is why in June 2018, the Government of Canada enacted the *Federal Framework on Post-Traumatic Stress Disorder Act* (the Act), which called for the development of a *Federal Framework on PTSD* (the Framework). The Act, as well as the Observations provided by the Senate Standing Committee on National Security and Defence at the time of enactment, are included as **Appendix A**.

The Act specified three priority areas for the Framework:

a) Improved tracking of the incidence rate and associated economic and social costs of PTSD;

b) The establishment of guidelines regarding:

   i) the diagnosis, treatment and management of PTSD, and

   ii) the sharing throughout Canada of best practices related to the treatment and management of PTSD; and

c) The creation and distribution of standardized educational materials related to PTSD for use by Canadian public health care providers that are designed to increase national awareness about the disorder and enhance its diagnosis, treatment and management.

This Framework addresses occupation-related PTSD and builds on existing federal initiatives, such as *Supporting Canada's Public Safety Personnel: An Action Plan on Post-Traumatic Stress Injuries*, which focuses on supporting the mental health of public safety personnel, and the recently created Centre of Excellence on PTSD and Related Mental Health Conditions, funded by Veterans Affairs Canada.

The Framework acknowledges that people can be affected by PTSD outside of the occupational setting and broad applicability will be considered in the implementation of federal actions.

WHAT IS PTSD?

PTSD is a mental disorder that may occur after a traumatic event where there is exposure to actual or threatened death, serious injury, or sexual violence.[1] Potentially traumatic events include war/combat, major accidents, natural- or human-caused disasters, and interpersonal violence. PTSD can affect any person regardless of age, culture, occupation, sex, or gender.

According to the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5), a diagnosis of PTSD requires that the trauma be experienced through:[1]

- Direct personal exposure.
- Witnessing of trauma to others.
- Indirect exposure: learning that the traumatic event occurred to a family member or close associate.
- Firsthand repeated or extreme exposure to aversive details of a traumatic event(s).

Most people recover in a relatively short period following a traumatic event; however some people experience symptoms that worsen and persist over months or years. In some cases, the onset of symptoms may not appear until months or years after the experience. At present, we do not fully understand the biological, psychological, social, and environmental reasons for why individuals can react very differently to the same traumatic event.

A diagnosis of PTSD requires that symptoms be present for more than one month and cause significant distress or impairment in function. Symptoms of PTSD include[1]:

- Recurring, involuntary, intrusive, and distressing memories, nightmares, and/or flashbacks.
- Avoidance or attempts to avoid distressing memories, thoughts, feelings, or reminders of the event.
- Persistent negative changes in thoughts or mood (e.g., negative emotions, diminished interest in activities, inability to experience positive emotions, feelings of detachment).
- Changes in arousal or reactivity (e.g., irritable behaviour, angry outbursts, reckless or self-destructive behaviour, hyper-vigilance, exaggerated startle response, trouble concentrating, or disturbed sleep).

PTSD often occurs with other mental health conditions such as depression and substance use disorders; chronic diseases and conditions such as diabetes, high blood pressure, and chronic pain;[2,3] and, suicidal thoughts and behaviours.[4,5]

The terms posttraumatic stress injury (PTSI) and operational stress injury (OSI) are increasingly used to describe mental health conditions related to traumatic events. On occasion, PTSI and OSI have been used interchangeably. By definition, a PTSI does not necessarily involve an injury following exposure to a traumatic event while serving in a professional capacity, whereas an OSI implies the injury was sustained as a result of operational duty. These non-clinical terms capture the full range of mental injuries that can occur following a traumatic event and include PTSD, depressive disorders, anxiety disorders, or substance use disorders. PTSI and OSI are used in an intentional effort to reduce stigma associated with other language (e.g., mental disorder or mental health problems).[6]

Although the Framework focuses on PTSD as a clinically diagnosed mental health condition, the Government of Canada acknowledges that many different mental health conditions can result from exposure to traumatic events.

Can PTSD Be Prevented?

Currently, the only way we know of to prevent PTSD is to avoid exposure to traumatic events. Although mental health education and resiliency training can be beneficial, there is no evidence that these programs prevent the development of PTSD. The same is true of pre- or post- trauma debriefings.[7,8]

We do know that mental health education to increase knowledge and coping skills can alert people to early signs and symptoms of conditions such as PTSD, and may lead to early treatment-seeking behaviours. Timely evidence-based treatment of PTSD will help decrease the risk of long-term negative outcomes. This is especially important in cases where trauma exposures are more frequent due to the nature of an occupation.[9]

Following exposure to a potentially traumatic event, many people experience distressing symptoms such as poor sleep, nightmares, and increased anxiety. However, the majority will recover from these symptoms spontaneously. Time, self-care and social support help, but some will go on to develop PTSD. Some evidence suggests that the severity of a traumatic event, lack of social support, or a history of adverse childhood experiences or previous mental health conditions can add to the risk of developing PTSD.[10,11,12]

WHO IS AFFECTED BY PTSD?

About three quarters of Canadians are exposed to one or more events within their lifetime that could cause psychological trauma.[13]

A study using nationally representative data collected in 2002, based on self-reported symptoms, indicated that lifetime prevalence of PTSD in Canada was 9.2% and current (past month) prevalence was 2.4%.[13]

The *Canadian Community Health Survey—Mental Health*, a nationally-representative survey in which participants were asked if they had a current diagnosis of PTSD, indicated prevalence rates of 1.0% in 2002 and 1.7% in 2012. An increase over time was observed among females—1.2% in 2002 and 2.4% in 2012. The rates for males remained stable over time.[14]

PHAC conducted a systematic review on the prevalence of PTSD in Canadian studies and found that data on PTSD is limited and updated statistics are needed. Reported rates of PTSD can vary across surveys because questions about PTSD are asked in different ways. The timeframe of questions can be shorter (e.g., past month) or longer (e.g., lifetime), with longer timeframes leading to higher rates. Some questionnaires collect data based on PTSD symptoms while others ask if an individual has been diagnosed with PTSD.[15]

Many individuals with PTSD will not seek treatment because of stigma, lack of awareness, or other barriers. Also, individuals may be reluctant to share detailed mental health information. As a result, questions about a PTSD diagnosis may lead to different estimates than those based on symptom assessments, and both methods likely underestimate the true prevalence.

Sex, gender, and other factors can influence risk and vulnerability, access to health services, and socioeconomic consequences at different points in the life cycle. These factors intersect and can result in unique challenges that further complicate PTSD assessments and require additional research.

PTSD in Men and Women

- PTSD appears to be twice as common in women as in men.[16]
- Men and women present symptoms of PTSD differently[17,18]:
  - Women are more likely to report symptoms of numbing and avoidance, as well as concurrent mood and/or anxiety disorders.
  - Men are more likely to report symptoms of irritability and impulsiveness, as well as concurrent substance use disorders.
- The uneven distribution of men and women in certain professions leads to research challenges. For example, over 90% of Canadian nurses are women[19,20] and over 95% of Canadian firefighters are men.[21]

*Information about other gender identity and expressions is provided in **Appendix B.**

Below are some available data, evidence, and considerations for specific populations in Canada that are at increased risk for developing PTSD. This information is not intended to exclude any occupational group or population. Research and evidence about PTSD continues to evolve and it is possible that there are additional groups or occupations at higher risk.

Canadian Armed Forces Serving Members and Veterans

Canadian Armed Forces Serving Members

There are two broad categories of Canadian Armed Forces (CAF) membership: 1) Regular CAF members, who make a full-time commitment and often have dedicated their career to military service; and 2) Reserve Forces who generally work part-time in addition to pursuing their regular career or education. Both types of members can be enrolled in the Navy, Army, or Air Force.

Military-related PTSD can result from exposure to traumatic events experienced during training, deployment-related combat, peacekeeping and humanitarian operations, or as a result of non-deployment trauma (e.g., military police).[22] PTSD rates among serving military personnel and Veterans increase proportionately to their exposure to traumatic and disturbing events such as participating in combat roles, and events that transgress deeply held moral and ethical standards. (See text box on the concept of moral injury).[23] Among serving military personnel and Veterans, exposure to non-military related potentially traumatic factors, such as adverse childhood experiences, are also thought to play a role in susceptibility to PTSD in later life.[24]

The Canadian Armed Forces (CAF) has reliable estimates of mental disorders in serving CAF members based on collaborative work with Statistics Canada and other related studies. According to a 2014 report, the number of active CAF Regular Forces members who reported symptoms of PTSD nearly doubled from 2002 to 2013 (from 2.8% to 5.3%).[25] In 2013, 16.5% of active CAF members had evidence of one or more of six mental disorders such as Major Depressive Disorder (MDD), PTSD, and Generalized Anxiety Disorder (GAD). Traumatic events experienced during deployment may be associated with a higher risk for mental disorders and suicide.[26]

What is Moral Injury?

Moral Injury is an evolving concept that continues to be discussed among experts. It usually refers to a type of psychological trauma characterized by intense guilt, shame, and spiritual crisis. It can result from experiencing a significant violation of deeply held moral beliefs, ethical standards, or spiritual beliefs, experiencing a significant betrayal, or witnessing trusted individuals committing atrocities. Moral Injury has also been described as an injury to identity, core being, spirit, and sense of self that results in fractured relationships.[6]

Canadian Armed Forces Veterans (Former CAF Members)

Veterans Affairs Canada (VAC) has reliable estimates of the prevalence of self-reported PTSD diagnoses in Veterans based on collaborative work with Statistics Canada. The prevalence of PTSD in Regular Force Veterans released from service during 1998–2012 and surveyed in 2013 was 13.1%. The rate was significantly higher than the general population, even after accounting for age and sex.[27] The prevalence of self-reported PTSD in Reserve Force Veterans

deployed on operational duties with the Regular Force was 7.5%, which was also higher than the general population. Similar results were seen in Regular Force Veterans released during 1998–2015 and surveyed in 2016, where 16.4% reported PTSD.[28] In international studies, PTSD is usually higher in Veterans than among active serving members.[23] This may reflect in part the stresses that Veterans face when they leave the military and transition to civilian life or by differences in survey methods.[27]

Public safety personnel

Public safety personnel include frontline personnel who ensure the safety and security of Canadians across all jurisdictions such as police, firefighters (career and volunteer), paramedics, correctional employees, border services personnel, operational and intelligence personnel, search and rescue personnel, Indigenous emergency managers, and public safety communications personnel (e.g., 911 operators, dispatchers). Given the broad range of occupations within the public safety community, it is important to recognize their distinct contexts and considerations related to experiences of trauma.

Public safety personnel may be at increased risk of PTSD because their jobs routinely expose them to a range of traumatic events.[29] They respond to crimes, accidents, and disasters and may witness or experience serious injuries, threats to life or death, as well as long-term exposure to disturbing material or communications. Feelings of guilt and shame may also contribute to the development of PTSD symptoms, particularly in situations where they were unable to help, identified with the victim or were overwhelmed by the event.[30]

In a study conducted in 2016 and 2017, 44.5% of participating public safety personnel reported clinically significant symptoms consistent with one or more mental disorders. An estimated 23.2% showed symptoms of PTSD.[31]

Health care providers

Nurses, physicians, psychologists, social workers, and other health care providers witness trauma, pain, suffering, and/or death on a regular basis in their work to care for the health of individuals, families, and communities.[32] Research about PTSD in health care providers in Canada is limited; however, available studies indicate that PTSD rates among health care providers are higher than in the general population.[33] For example, a report released in 2015 by the Manitoba Nurses Union indicated that one in four participating nurses reported PTSD symptoms. The same document indicated that 43% of new nurses experience high levels of psychological distress because of their work.[19, 20]

Health care providers may also be called to care for individuals who remind them of loved ones, which can result in feeling guilt and shame if they are unable to help.[19,34] They may experience higher rates of compassion fatigue and/or burnout when caring for, empathizing with, and emotionally investing in, people who are suffering.[35] In addition, violence toward health care providers, such as nurses, is a serious concern and likely functions as a contributing factor to the development of PTSD.[19,20, 36]

Other occupations

There are other occupational roles or professions that also face an increased risk for developing PTSD. For example:

- Jurors may experience vicarious trauma as a result of exposure to traumatic content in the context of legal trials related to violent crimes.[37]
- Journalists are exposed to potentially traumatic events when they arrive early on the scene and/or report about the circumstances of the event. Journalists (especially war correspondents) may also face an increased risk of personal physical harm.[38]

Indigenous people who work in high-stress occupations and additional considerations[b]

First Nations, Inuit and Métis individuals working in high-stress occupations (such as public safety personnel and health care providers) face unique challenges.

These frontline workers[c] are an integral part of Indigenous communities. Consequently, communities often have high expectations towards these workers. As a result, it may be difficult for frontline workers to set and maintain personal and work-life boundaries. In some cases, they may be the only one providing a specialized service in their community, and may have to intervene in a professional capacity during traumas and critical incidents involving family members or friends. They may also take on multiple roles in their community (e.g., as both a frontline worker and as a decision maker or leader determining how to respond organizationally or politically to a family or community crisis).[39] As a result, they may experience many different impacts from a singular trauma, which can lead to feelings of helplessness, numbness, avoidance and a reduction in empathy.[32]

In addition, First Nation, Inuit and Métis frontline workers often serve communities that experience higher rates of poverty, mental health conditions, crime, or victimization.[40] Other challenges they may face include lack of resources and unsupportive human and organizational infrastructures. These challenges may worsen their own histories of trauma and put them at greater risk of experiencing mental health conditions, including PTSD.[41] The lack of resources and infrastructure also means there is often limited support to help frontline workers deal with the cumulative impact of stress and trauma, leading to potential long-term negative effects on their mental health and wellbeing.[42] All of these factors are magnified for workers in remote communities, who may also be confronted with isolation and extreme environmental conditions.[41]

First Nations, Inuit, and Métis Peoples working in high-stress occupations outside Indigenous communities (e.g., in an urban center like Toronto or while serving in the Canadian Armed Forces) may also have their own personal history of trauma, which can increase their risk of developing mental health conditions, including PTSD.[43]

Finally, non-Indigenous frontline workers serving Indigenous communities may also experience challenges. For example, many Indigenous communities employ or receive nursing services by non-Indigenous nurses. These nurses may find

[b] First Peoples Wellness Circle Policy Brief on PTSD: https://11d19480-8ac9-4dee-a0f8-02f67b6947c6.filesusr.com/ugd/0265ae_ec211634a1b04691aadf6ae72ab7dc1b.pdf

[c] For the purpose of this section, frontline workers include public safety personnel, health and social service providers, including mental health care and support.

themselves ill-equipped to manage the layers of trauma with the scarcity of human and practical resources available to them which can affect their wellbeing and mental health.[44]

Unique factors that impact PTSD in Indigenous Peoples

Historical and current trauma among First Nations, Inuit and Métis is significant and well documented by initiatives such as the Truth and Reconciliation Commission and the Inquiry into Missing and Murdered Indigenous Women and Girls.[45,46] Past colonization policies have resulted in intergenerational, social and community trauma, which continue to impact the health and wellness of Indigenous Peoples and communities.[47]

First Nations, Inuit and Métis have distinct histories, contexts, world views and knowledge systems that need to be considered to understand and treat PTSD within those populations, whether in an occupational setting or not.

Other populations

Many people are at increased risk for PTSD as a result of experiences outside of an occupational setting such as survivors of sexual or interpersonal violence, refugees, LGBTQ2 populations, Indigenous Peoples, people experiencing homelessness, as well as survivors of major accidents or disasters. Each of these populations face a unique set of circumstances, complexities, and challenges that impact the diagnosis, treatment, and management of PTSD. **Appendix B** provides a high-level overview of PTSD from experiences outside of occupational settings.

ORGANIZATIONAL ROLES AND RESPONSIBILITIES

To address PTSD in Canada, we require the knowledge, expertise, and involvement of organizations from multiple sectors and disciplines. These include federal, provincial/territorial, regional and local governments, the research and academic community, pan-Canadian health organizations, non-government organizations, employers, and community organizations.

In addition to these organizations, health care providers are central to the diagnosis, treatment, and management of PTSD. The experiences and expertise of people with lived experience – the individuals living with PTSD and their families and peers –inform our efforts and compel us to action.

This section outlines some of the current roles and responsibilities of governments, employers, and other stakeholders.

Government of Canada

The Government of Canada fosters connections, provides information, supports research and innovation, and undertakes activities to promote and protect the physical and mental health of Canadians. The Government of Canada is a leader, partner, funder, and convenor on issues of importance to Canadians, including PTSD.

The Government of Canada provides or funds some direct health care services (including mental health services) to groups under federal jurisdiction. These groups include serving members of the CAF, First Nations living on reserve and Inuit living in the North, and federal inmates.

The federal government also funds and administers supplementary and occupational health care benefits (including coverage for mental health services) for members of the Royal Canadian Mounted Police (RCMP), Veterans, First Nations and Inuit populations, as well as refugees, asylum claimants and other specific, vulnerable foreign nationals. Many people within these populations are at higher risk of developing PTSD.

The federal government is Canada's largest employer and has prioritized workplace mental health by adopting procedures and measures, as well as championing initiatives that promote positive mental health in the workplace.

Provincial and territorial governments

Provincial and territorial governments provide leadership, policy direction, and programs that support the health of their residents, and the delivery of services under their jurisdiction. This includes health care and other social services, including mental health supports, such as hospital services, crisis intervention, treatment, and follow-up. Provinces and Territories also have workers compensation boards, which have responsibilities related to health and labour issues.

All provinces and territories have mental health strategies, which focus on upstream approaches (i.e., promote positive mental health, resiliency, and wellness across the lifespan), mental health services, stigma reduction, and treatment. These strategies recognize the impacts of trauma (including intergenerational and historical trauma) on mental health and as a risk factor for substance-related harms and suicide.

Most provinces and territories have recognized the impact that certain occupations can have on an individual's mental health and have implemented corresponding presumptive legislation for workers' compensation claims. (See text box). The intention is to allow for early intervention, which should help to mitigate aggravation or recurrence of mental health challenges such as PTSD.

Presumptive Legislation

Presumptive legislation facilitates workers' compensation coverage by presuming, in the absence of evidence to the contrary, that the injury or illness is work related. Presumptive legislation may be limited to PTSD and a narrow group of occupations (e.g., police, firefighter, paramedic) and/or may be more broadly applicable to mental illnesses beyond PTSD and to a broader scope of occupations, or all occupations.

Employers

All employers including federal, provincial/territorial, and municipal governments, as well as non-governmental organizations and private sector companies have a responsibility to ensure the health and safety of their employees. Employers must think ahead and act proactively to minimize or protect against psychological injuries and promote psychological wellbeing. Wherever possible, these efforts should be based on peer-reviewed research and the best available practices as indicated by scientist-practitioners with appropriate mental health expertise and experience.

In occupations where there is a higher risk of employees developing PTSD, some employers have implemented specific mental health initiatives. The CAF developed the Road to Mental Readiness (R2MR) training program to promote early awareness of distress, encourage care-seeking, normalize mental health challenges, and provide evidence-based skills to manage the demands of service and daily life. The CAF recently adapted the most recent

version of the R2MR program to create an edition appropriate for delivery to public safety personnel and this training is being made available across Canada through the collaborative efforts of Public Safety Canada, the CAF, and the Canadian Institute of Public Safety Research and Treatment (CIPSRT).

Many workplaces (including the federal government) have established employee assistance programs (EAP) to assist employees with personal problems and/or work-related issues that may impact their job performance as well as their physical/mental health, and emotional wellbeing. EAPs usually offer free and confidential assessments, short-term counselling, referrals, and follow-up services for employees and their families.

Stakeholder and community groups

Across Canada, multiple stakeholders and communities are mobilizing to address the challenges of PTSD and related mental health conditions. These stakeholder organizations (often led by individuals with lived experience) operate at both the national and regional level. They can provide services and peer support, as well as leadership and expertise to strengthen research, innovation, knowledge exchange and awareness, and to develop tools and resources for Canadians, employers, and health care providers. Many stakeholder organizations work closely and collaboratively with governments to inform policy, and advocate on behalf of people experiencing PTSD.

INFORMING THE FRAMEWORK

The implementation of the *Federal Framework on Post-Traumatic Stress Disorder Act* and the resulting *Federal Framework on PTSD* was coordinated by PHAC in collaboration with multiple partners and stakeholders.

PHAC engaged with more than fifteen federal government departments to foster connections and share initiatives related to PTSD and other occupation-related mental health conditions. PHAC also consulted with stakeholder groups who fell within the scope of the Act and other experts in the field of PTSD and mental health.

In October 2018, an early stakeholder consultation was held on the margins of the Canadian Institute for Military and Veteran Health Research (CIMVHR) Forum. This consultation was attended by members of the CIPSRT Public Safety Steering Committee, members of the CIMVHR Technical Advisory Committee, and key federal departments.

As specified in the Act, in April 2019, a National Conference on PTSD took place in Ottawa, Ontario. This conference was the main engagement mechanism to obtain a variety of perspectives for the development of the Framework. The conference brought together 200 diverse participants and encouraged collaboration and knowledge sharing across sectors and disciplines. Participants included: representatives of occupational groups at higher risk for PTSD, people living with PTSD and their support networks, researchers/academics, health care providers, representatives of populations at higher risk for PTSD, Indigenous groups, federal and provincial government representatives, workers' compensation board representatives, and Pan-Canadian health organizations.

To ensure the Indigenous context and considerations were well reflected in the Framework, PHAC continued to engage with Indigenous organizations through a First Nations Reference Group on PTSD, the Métis Nation Health Committee, and the National Inuit Committee on Health.

Key themes from the National Conference on PTSD

- ***Health care benefits and access to care and resources vary across the country and across different occupational groups*** – Some occupational groups have access to a variety of educational tools and services, but others struggle to receive basic supports. These disparities were particularly salient for individuals in rural and remote communities, as well as those in volunteer positions, and in certain medical professions, such as nurses. For example: a nurse living in a remote location may experience a very different path to treatment than a nurse located in an urban centre; volunteer firefighters may not be eligible for the same health benefits as their paid counterparts; and, services and benefits offered to municipal police services may not be analogous to those offered federally to the RCMP.
- ***There is a need to achieve parity between physical and mental health*** – There is general knowledge of PTSD, but stigma remains an ongoing barrier to care and treatment. Participants shared that some individuals fear that seeking help will hinder their careers. Others shared that while workplace policies may be in place to support individuals with PTSD, longstanding occupational cultures and organizational leadership continue to reinforce the perception that mental health conditions such as PTSD are a sign of weakness. Participants also noted the importance of continued research, including in the field of identifying biological markers for PTSD.
- ***A number of resources exist, but there is a need for comprehensive ways to share evidence-based best practices*** – Participants reported that the amount of information on PTSD can be overwhelming and there may be opportunities to use or build on successful initiatives; however, knowing what is truly of value to help persons living with PTSD in their recovery can be extremely difficult. Participants expressed the need for standardized evidence-based resources that can be adapted (e.g., based on the community, culture, sex or gender). Indigenous participants expressed the need for studies that involve individuals of Indigenous ancestry and that use culturally appropriate methodologies. Participants also noted the need for consistent language and terminology around PTSD.
- ***PTSD has impacts beyond the individual***. ***There is a need to consider how families, children and the diagnosed individual's support networks are affected*** – On several occasions participants shared that spouses, children, family members and other support networks of those who experience PTSD are significantly affected by a loved one's PTSD. Individuals in the immediate social circle of a person with PTSD can be important assets in recovery; however, the same individuals will also require effective supports to best assist the person living with PTSD, as well as to maintain their own mental health and wellbeing.
- ***There is a need for quality and timely data, as well as qualitative input and insight from individuals with lived experience to inform policies and programs*** – Participants and experts agreed that the current available data on PTSD has significant gaps and is, at times, outdated. They commented on the power of sharing personal stories in helping those who are struggling, and in informing policies and programs. Participants also emphasized the importance of sharing personal stories in a safe and sensitive way.
- ***There is a need to improve organizational capacity to respond to and support employees at higher risk of developing PTSD*** – More proactive and early intervention initiatives are required to help employees recognize PTSD symptoms, seek treatment when needed, and strengthen their support networks and resilience (e.g., including peer support, return-to-work strategies, and training that promotes healthy coping). Finally, participants emphasized the importance of trauma-informed approaches as a means of reducing stigma, supporting employees, and shifting organizational culture so that all staff are aware and able to integrate knowledge of trauma into practice.

PART II

THE FEDERAL FRAMEWORK ON PTSD

FEDERAL FRAMEWORK ON PTSD—AT A GLANCE

SCOPE

The focus of the Framework is on occupation-related PTSD. The Framework also acknowledges people affected by non-occupation-related PTSD and broad applicability will be considered in the implementation of federal actions.

PURPOSE

Strengthen knowledge creation, knowledge exchange and collaboration across the federal government, and with partners and stakeholders, to inform practical, evidence-based public health actions, programs and policies, to reduce stigma and improve recognition of the symptoms and impacts of PTSD.

VISION

A Canada where people living with PTSD, those close to them, and those at risk of developing PTSD, are recognized and supported along their path toward healing, resilience, and thriving.

GUIDING PRINCIPLES

- Complement current initiatives and leverage partnerships
- Advance compassionate, non-judgemental and strengths-based approaches
- Base initiatives on evidence of what works or shows promise of working
- Understand and respond to equity, diversity and inclusion
- Apply a public health approach

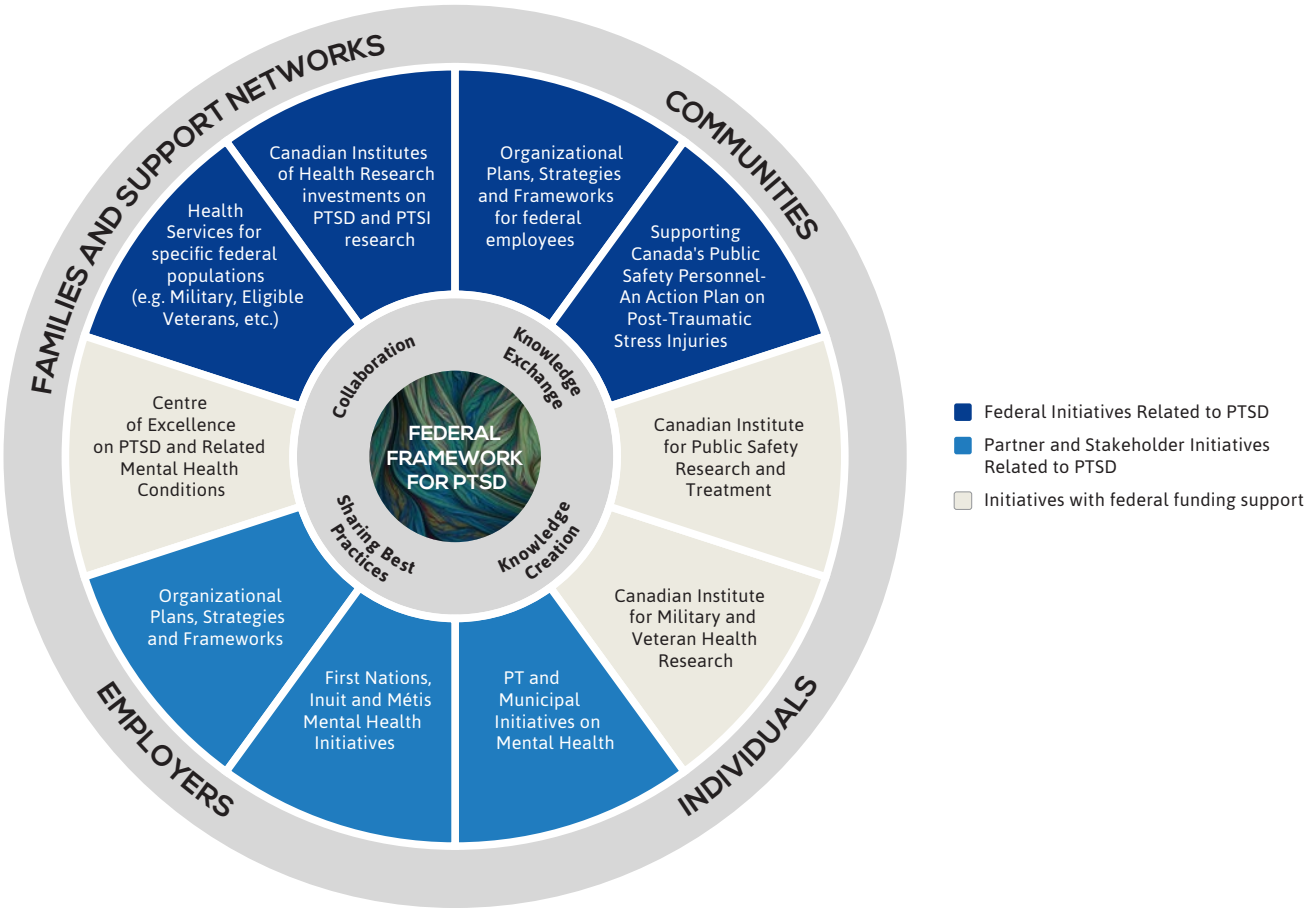
PRIORITY AREAS	FEDERAL ACTIONS
DATA AND TRACKING	▸ Explore strategies to support national surveillance activities and examine the feasibility of using health administrative data and enhanced data linkages to capture and report on PTSD. ▸ Continue supporting data collection on PTSD.
GUIDELINES AND BEST PRACTICES	▸ Work with partners and engage experts to compile existing guidance on PTSD and identify where gaps may exist. ▸ Continue to support research to bridge PTSD-related information gaps, inform effective guidance for health care providers, and advance evidence-based decision making.
EDUCATIONAL MATERIALS	▸ Work with partners and engage health care providers to identify current PTSD educational materials, understand the educational gaps, and seek advice on best practices for the dissemination, adaptation, and uptake of educational materials.
STRENGTHENED COLLABORATION	▸ Work with partners and stakeholders to identify the best mechanism(s) to increase collaboration among key departments, partners and stakeholders, as well as for ongoing sharing of information, including uptake of common and culturally appropriate terminology, definitions, and safe language about PTSD and trauma.

SCOPE AND PURPOSE OF THE FRAMEWORK

The Federal Framework on PTSD establishes the Government of Canada's vision, guiding principles, and actions to address occupation-related PTSD, as they relate to the three legislated areas of priority.

The purpose of the Framework is to strengthen knowledge creation, knowledge exchange and collaboration across the federal government, and with partners and stakeholders, to inform practical, evidence-based public health actions, programs and policies, to reduce stigma and improve recognition of the symptoms and impacts of PTSD.

Appendix C lists PTSD initiatives currently underway in Canada, including federal initiatives to support high-risk populations. The following graphic illustrates how the various ongoing initiatives can connect to the Framework to help those impacted by PTSD.



VISION

A Canada where people living with PTSD, those close to them, and those at risk of developing PTSD, are recognized and supported along their path toward healing, resilience, and thriving.

GUIDING PRINCIPLES

The following principles are intended to guide the actions outlined in the Framework, as well as other efforts by the Government of Canada to address PTSD.

- **Complement current initiatives and leverage partnerships.** Improve coordination, collaboration, and linkages across government and among non-governmental organizations, Indigenous organizations and communities, the private sector, provinces and territories, research organizations, communities, practitioners, and those with lived experience.
- **Advance compassionate, non-judgemental, strengths-based and trauma-informed approaches.** Engage with people who have lived experience of PTSD. Be aware of how stigma, discrimination and racism increase risks and create barriers to treatment. Apply trauma-informed approaches: understand the impact of trauma; create emotionally, culturally, and physically safe environments; foster opportunities for choice, control and collaboration; provide a strengths-based approach to support coping and resilience.
- **Base initiatives on evidence of what works or shows promise of working.** Recognize the importance of research in generating evidence and knowledge about PTSD. Ensure high-quality information is available, and apply research results to new and existing interventions, treatment, policies, programs, and training across Canada.
- **Understand and respond to equity, diversity and inclusion.** Ensure that approaches to education, treatment, and reintegration into society and the workplace are adaptable and individualized to occupational settings and realities. Consider culture, including Indigenous cultures, community, sex, gender, and other identity factors, such as race and ethnicity. Apply culturally safe approaches that ensure people can draw strength from their identity, culture, spirituality, and community in an environment that is free from racism and discrimination.
- **Apply a public health approach.** PTSD is a public health issue. Focus on the population or community and emphasize protective factors such as mental wellness, social cohesion, culturally appropriate and safe programs and services (particularly at the community level) to build safe and healthy environments, resilience, and coping skills.

PRIORITY AREAS

The *Federal Framework on PTSD Act* outlines three priority areas to be addressed in the Framework. These areas formed the basis of consultations with partners and stakeholders and were discussed in depth during the National Conference on PTSD.

Based on consultations, an additional priority area was added to focus on strengthening collaboration and linkages among partners and stakeholders.

This section provides an overview of these priority areas and their drivers, considerations, and the federal actions needed to advance them.

PRIORITY AREA 1

Improved tracking of the rate of PTSD and its associated economic and social costs

Data on PTSD in Canada is limited. To better inform policies and programs and to improve our understanding of PTSD and its risk factors, there is a need for high-quality, ongoing, and timely data collection, surveillance, and research, as well as insights from individuals with lived experience. Nationally representative data can identify how many Canadians are living with PTSD and the associated risk factors. Routine collection of data can also measure trends over time, and inform policy and program interventions. A variety of PTSD data collection tools are available but the approaches differ and this process is further hampered because the diagnosis of PTSD is complex, and health care providers may not always recognize or properly assess symptoms. In addition, many individuals do not realize they may have PTSD or seek care.

The Act calls for improved tracking of the *incidence* (the number of new cases of PTSD over a period of time); however, stakeholders, researchers, and policy-makers have recommended that first and foremost, we need an understanding of the *prevalence* of PTSD (the number of new *and* existing cases).

Research and data collection on certain sub-populations is taking place, but further effort should focus on Canadian population-level data. Population-level data establishes a prevalence estimate for the general population that serves as a point of comparison for estimates in sub-populations, including those at increased risk of PTSD.

The Act also calls for improved tracking of the associated economic and social costs of PTSD so we can fully understand impacts on individuals living with PTSD, their families, and their communities. These costs can include those related to lost wages, treatment, lost productivity, substance-related harms and/or mental health conditions, homelessness, etc. In order to generate accurate estimates of economic and social costs, we first need a clearer picture of PTSD prevalence in Canada.

Advancements in data collection, insights into existing data-related initiatives, and a deeper understanding of the social and economic costs of PTSD will provide a more complete picture of PTSD in Canada and therein better inform the development of policies, tools, and interventions.

Data on PTSD in Canada is limited and requires updating.

Recognizing the importance of data in understanding PTSD and its impacts, and in informing policies and programs, the Government of Canada will:

- Explore strategies to support national surveillance activities to measure the rate of PTSD and its associated costs and examine the feasibility of using health administrative data and enhanced data linkages to capture and report on PTSD. This work will be led by PHAC in collaboration with other partners and stakeholders.
- Continue supporting data collection to better understand PTSD and related mental health conditions, through ongoing investments and initiatives.

PRIORITY AREA 2
Promotion of guidelines and sharing of best practices related to the diagnosis, treatment and management of PTSD

Diagnosing, treating, and managing PTSD is complex. What leads to PTSD in one person may be completely different for another person. People who experience PTSD symptoms may experience other concurrent mental health conditions (e.g., anxiety disorders or substance use disorders), which can hamper recognition, diagnosis, and treatment. Other factors such as individual differences, personal preferences, health provider expertise, resource availability, and the ability to access resources and services may also affect recognition, diagnosis, and treatment.

There is no one-size-fits-all approach to treat and manage PTSD. Treatment plans need to be individualized based on a person's clinical presentation and personal experience, and should recognize cultural, occupational, sexual and/or gender-based differences. Relevant social determinants of health, trauma-informed care, and reintegration practices must also be at the centre of any treatment plan to ensure physical, cultural and emotional safety.

Examples of Clinical Practice Guidelines on PTSD

- International Society for Traumatic Stress Studies (ISTSS): *PTSD Prevention and Treatment Guidelines: Methodology and Recommendations* (March, 2019; US)
- National Institute for Health and Care Excellence (NICE): *Post-traumatic stress disorder – NICE guideline* (December, 2018; UK)
- US Department of Veterans Affairs and Department of Defense (VA/DoD): *Clinical Practice Guideline for the Management of PTSD and Acute Stress Disorder* (2017; US)
- American Psychological Association (APA): *Clinical Practice Guideline for the Treatment of PTSD* (February, 2017; US)
- Anxiety Disorders Association of Canada: *Canadian Clinical Practice Guidelines for the Management of Anxiety, Posttraumatic Stress and Obsessive-Compulsive Disorders* (2014; Canada)

A number of clinical practice guidelines provide practical, evidence-based recommendations for the diagnosis, treatment, and management of PTSD. (See text box.) Guidelines require regular updating as research evolves, which require time and specific expertise. The development, review, and updating of clinical practice guidelines is the responsibility of guideline groups, health authorities or health care providers, along with their associations, accreditors, and regulators.

Guidance and best practices also exist to guide service delivery and models of care for specific populations, but gaps remain, and awareness of these tools is sometimes lacking.

There are also emerging and innovative interventions, such as peer support programs, meditation, internet-based therapies, couples-based trauma treatment, and land-based activities, which provide options that may help in the healing process based on individual needs and pace of recovery. Current dialogue on emerging treatments also includes the possible use of cannabis to manage symptoms of PTSD. For Indigenous Peoples, traditional ceremonial practices enacted in cultural settings can promote healing and wellness. Emerging and innovative interventions may not be included in clinical practice guidelines and are currently considered as adjuncts to first-line evidence-based treatments. Additional and systematic research into emerging and innovative interventions is required to build the evidence base and to ensure their safety, efficacy, and effectiveness.

With more research, we can better determine which policies, programs, and treatments will make the most difference for the mental wellness and resilience of a greater number of Canadians impacted by PTSD.

Knowledge transfer and the sharing of best practices around innovative interventions should be undertaken in a timely way to benefit those living with PTSD and their support networks.

Evidence-based guidelines and best practices are essential to ensure the best care and support of those affected by PTSD.

Recognizing that many resources already exist, but awareness of these tools is sometimes lacking, and recognizing that research is essential in the advancement of guidance development, the Government of Canada will:

- Through PHAC, work with partners and engage experts to compile existing guidance on PTSD, and identify where guidance gaps may exist.
- Support research, including applied research, through existing investments, to bridge PTSD-related information gaps, inform effective guidance for health care providers and advance evidence-based decision making for policy and program makers across all levels of government and key partners and stakeholder organizations.

PRIORITY AREA 3
Creation and distribution of educational materials related to PTSD to increase national awareness and enhance diagnosis, treatment and management

Canadian health care providers are often the first line of contact for people experiencing symptoms of PTSD. Health care providers play an important and influential role in helping those affected find appropriate treatments and supports. To be effective, health care providers need to be well informed and knowledgeable about PTSD and how it impacts different populations. Educational tools and resources exist, but there is limited understanding of the quality and availability of tools and resources for health care providers.

The Act specifically identified the need for educational materials for "public health care providers"; however, partners and stakeholders also stressed the need for tools and resources for individuals experiencing symptoms of PTSD, their support networks, and for employers and workplaces.

Individuals experiencing symptoms of PTSD need tools and resources that are accessible, clear, concise, and that encourage them to seek help. There is no single mechanism to share these materials—instead, a breadth of educational tools and resources are available across Canada in a variety of formats. For example, general information on the signs, symptoms, causes, risk factors, diagnosis, and treatment of PTSD can be found on non-governmental organization (NGO) websites, including the Canadian Mental Health Association, the Centre for Addictions and Mental Health, and the Canadian Psychological Association.

The PTSD Coach Canada mobile app provided by VAC is available to people who may be seeking additional information and resources on PTSD. It features information and self-help tools based on research. The app, which is available to all Canadians, can be used as an education and symptom management tool, prior to, or as part of in-person care provided by a health care provider.

Family members and support networks of people experiencing PTSD, especially spouses**,** are often the first to recognize early warning signs and encourage their loved one to seek support. Families and support networks need specialized tools and resources that can help them recognize symptoms and cope with the impact of PTSD on their own lives.

This is especially true for children of people living with PTSD, who may be affected in multiple ways and may not understand what is happening to their parent or family member. Symptoms of PTSD, and the stress of coping with them, can impact a parent's ability to meet their child(ren)'s basic physical, psychological, emotional and spiritual needs, and their need for social and intellectual development. Educational materials for families and support networks need to emphasize coping strategies and point to available resources for support.

VAC publications on *PTSD and the Family* are good examples: www.veterans.gc.ca/public/pages/publications/system-pdfs/pstd_families_e.pdf or www.veterans.gc.ca/eng/health-support/mental-health-and-wellness/understanding-mental-health/ptsd-and-the-family.

Employers and workplaces have a crucial role in raising awareness about PTSD, preventing psychological injury, promoting psychological wellbeing and providing support to employees with PTSD. Workplace educational tools exist, such as the Road to Mental Readiness and The Working Mind programs. This content has already been adapted for some workplaces, but given diverse cultures and contexts, may need to be further adapted for applicability to specific audiences.

Trauma-informed policies in the workplace also promote resilience, encourage employees to seek early intervention, and reduce stigma toward mental health issues in the workplace.

Providing high quality, compassionate, action-oriented information on PTSD can empower people with PTSD, their family and support networks, and employers/workplaces to recognize the symptoms and impacts of PTSD, and encourage them to seek support and treatment.

Recognizing the importance of education in raising awareness, reducing stigma, and enhancing PTSD diagnosis, treatment, and management, the Government of Canada will:

- Through PHAC, work with partners and engage with health care providers to identify current PTSD educational materials, understand information and educational gaps, and seek advice on best practices for their dissemination, adaptation, and uptake.

PRIORITY AREA 4
Strengthened collaboration and linkages among partners and stakeholders

A number of PTSD-related initiatives are currently underway in Canada, including federal initiatives to support high-risk populations, such as *Supporting Canada's Public Safety Personnel: An Action Plan on Post-Traumatic Stress Injuries*, and the recently created Centre of Excellence on PTSD and Related Mental Health Conditions, funded by VAC.

A concerted and coordinated effort is needed to ensure awareness of new and existing PTSD initiatives and to engage partners and stakeholders, including people with lived experience. Working collectively allows for meaningful linkages and informed action across the Government of Canada, as well as with provinces and territories, Indigenous governments and organizations and communities, non-governmental organizations, researchers, practitioners, occupational communities and individuals. Connecting our efforts helps prevent duplication and ensures that we build on new approaches or resources as they are developed.

Strengthening connections and working collaboratively also involves an exploration of terminology. Language is important, not only in establishing a common understanding, but also in reducing stigma. There are many terms that are used interchangeably to capture the range of symptoms and health concerns associated with exposure to trauma and a common language can help build consistency among stakeholders and partners.

The Canadian Institute for Public Safety Research and Treatment (CIPSRT), in collaboration with a number of experts, has developed a *Glossary* outlining definitions related to PTSD and trauma. A version of the Glossary was disseminated at the National Conference on PTSD to ensure a common understanding among participants as they provided their insights and perspectives. Recognizing that language changes over time, the Glossary is intended to be a living document that will be updated regularly to reflect contemporary consensus on language. The most current version of the Glossary is included in **Appendix D**.

Collaboration is essential to minimize duplication and maximize the impact of our efforts to address PTSD.

In recognition of the complexity of PTSD, the diversity of those affected, the many partners and stakeholders involved in managing PTSD and the wide range of initiatives underway, the Government of Canada will:

- Work via PHAC with partners and stakeholders to identify the best mechanism(s) for increased collaboration among key federal departments, partners, and stakeholders, as well as for ongoing sharing of information, including uptake of common and culturally appropriate terminology, definitions, and safe language related to PTSD and trauma.

PART III
MOVING FORWARD

PTSD SECRETARIAT

The PTSD Secretariat was established within PHAC to lead the implementation of the *Federal Framework on PTSD Act*. Since that time, the Secretariat has worked with partners and stakeholders together to inform the development of the Framework in a variety of ways, including the National Conference on PTSD in April 2019.

Given the numerous players, initiatives, and far-reaching impacts of PTSD in Canada, as well as the need for coordination of actions outlined in this Framework, the PTSD Secretariat will continue to exist at PHAC. The PTSD Secretariat will provide leadership and bring partners and stakeholders together to continue to foster connections, as well as to identify existing and possible collaborations to further support the progressing and evolving efforts to address PTSD.

The PTSD Secretariat will work with partners and stakeholders to leverage existing mechanisms, resources, and efforts to avoid duplication.

REPORTING TO PARLIAMENT

As mandated by the *Federal Framework on Post-Traumatic Stress Disorder Act*, PHAC will complete a review of the effectiveness of the Framework five years after the publication of the Framework. This review, which must be laid before each house of Parliament, will include a progress update on the priority areas and actions outlined in the Framework, and highlight any new initiatives and their results.

CONCLUSION

PTSD has a long history of being under-recognized, misunderstood and misdiagnosed. PTSD affects a significant number of Canadians; nevertheless, getting on a path to recovery can be extremely complex for these reasons. People living with PTSD are certainly impacted by the disorder, but so are their loved ones, colleagues, and support networks, all of whom also need to be supported as part of managing the disorder.

Achieving the vision set out in the Framework will require collaboration from multiple partners and stakeholders, including people with lived experience, their families and support networks, employers, researchers, health care providers, community organizations, and all levels of government. We encourage all partners and stakeholders to build on the vision and guiding principles of the Framework to advance initiatives in the area of PTSD.

The Framework is intended to encourage continuous open dialogue. The actions identified herein will undoubtedly continue to evolve as we learn more about PTSD through ongoing efforts across the Government of Canada and by the many partners and stakeholders.

PART IV
APPENDICES

APPENDIX A
FEDERAL FRAMEWORK ON PTSD ACT
AND OBSERVATIONS FROM THE SENATE COMMITTEE

CANADA

CONSOLIDATION

CODIFICATION

Federal Framework on Post-Traumatic Stress Disorder Act

Loi sur le cadre fédéral relatif à l'état de stress post-traumatique

S.C. 2018, c. 13

L.C. 2018, ch. 13

Current to November 19, 2019

À jour au 19 novembre 2019

Published by the Minister of Justice at the following address:
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OFFICIAL STATUS OF CONSOLIDATIONS

Subsections 31(1) and (2) of the *Legislation Revision and Consolidation Act*, in force on June 1, 2009, provide as follows:

Published consolidation is evidence
31 (1) Every copy of a consolidated statute or consolidated regulation published by the Minister under this Act in either print or electronic form is evidence of that statute or regulation and of its contents and every copy purporting to be published by the Minister is deemed to be so published, unless the contrary is shown.

Inconsistencies in Acts
(2) In the event of an inconsistency between a consolidated statute published by the Minister under this Act and the original statute or a subsequent amendment as certified by the Clerk of the Parliaments under the *Publication of Statutes Act*, the original statute or amendment prevails to the extent of the inconsistency.

CARACTÈRE OFFICIEL DES CODIFICATIONS

Les paragraphes 31(1) et (2) de la *Loi sur la révision et la codification des textes législatifs*, en vigueur le 1er juin 2009, prévoient ce qui suit :

Codifications comme élément de preuve
31 (1) Tout exemplaire d'une loi codifiée ou d'un règlement codifié, publié par le ministre en vertu de la présente loi sur support papier ou sur support électronique, fait foi de cette loi ou de ce règlement et de son contenu. Tout exemplaire donné comme publié par le ministre est réputé avoir été ainsi publié, sauf preuve contraire.

Incompatibilité — lois
(2) Les dispositions de la loi d'origine avec ses modifications subséquentes par le greffier des Parlements en vertu de la *Loi sur la publication des lois* l'emportent sur les dispositions incompatibles de la loi codifiée publiée par le ministre en vertu de la présente loi.

LAYOUT

The notes that appeared in the left or right margins are now in boldface text directly above the provisions to which they relate. They form no part of the enactment, but are inserted for convenience of reference only.

MISE EN PAGE

Les notes apparaissant auparavant dans les marges de droite ou de gauche se retrouvent maintenant en caractères gras juste au-dessus de la disposition à laquelle elles se rattachent. Elles ne font pas partie du texte, n'y figurant qu'à titre de repère ou d'information.

NOTE

This consolidation is current to November 19, 2019. Any amendments that were not in force as of November 19, 2019 are set out at the end of this document under the heading "Amendments Not in Force".

NOTE

Cette codification est à jour au 19 novembre 2019. Toutes modifications qui n'étaient pas en vigueur au 19 novembre 2019 sont énoncées à la fin de ce document sous le titre « Modifications non en vigueur ».

TABLE OF PROVISIONS

An Act respecting a federal framework on post-traumatic stress disorder

TABLE ANALYTIQUE

Loi concernant un cadre fédéral relatif à l'état de stress post-traumatique

S.C. 2018, c. 13

An Act respecting a federal framework on post-traumatic stress disorder

[*Assented to 21st June 2018*]

Preamble

Whereas post-traumatic stress disorder (PTSD) is a condition that is characterized by persistent emotional distress occurring as a result of physical injury or severe psychological shock and typically involves disturbance of sleep and constant vivid recall of the traumatic experience, with dulled responses to others and to the outside world;

Whereas there is a clear need for persons who have served as first responders, firefighters, military personnel, corrections officers and members of the RCMP to receive direct and timely access to PTSD support;

Whereas, while not-for-profit organizations and governmental resources to address mental health issues, including PTSD, exist at the federal and provincial levels, there is no coordinated national strategy that would expand the scope of support to ensure long-term solutions;

And whereas many Canadians, in particular persons who have served as first responders, firefighters, military personnel, corrections officers and members of the RCMP, suffer from PTSD and would greatly benefit from the development and implementation of a federal framework on PTSD that provides for best practices, research, education, awareness and treatment;

L.C. 2018, ch. 13

Loi concernant un cadre fédéral relatif à l'état de stress post-traumatique

[*Sanctionnée le 21 juin 2018*]

Préambule

Attendu :

que l'état de stress post-traumatique (ESPT) est un trouble qui se caractérise par une détresse émotionnelle persistante causée par une blessure physique ou un choc psychologique grave et entraîne généralement des troubles du sommeil, une remémoration vive et constante de l'expérience ayant causé le traumatisme, ainsi qu'un engourdissement des réactions à autrui et au monde extérieur;

que, de toute évidence, des personnes ayant occupé des fonctions de premier répondant, de pompier, de militaire, d'agent correctionnel ou de membre de la Gendarmerie royale du Canada ont besoin de recevoir, de façon directe et en temps opportun, du soutien pour l'ESPT;

que, même si des organismes à but non lucratif et des ressources gouvernementales, tant au niveau fédéral que provincial, sont consacrés au traitement de problèmes de santé mentale, y compris l'ESPT, il n'existe aucune stratégie nationale coordonnée qui permettrait d'étendre la portée du soutien de manière à offrir des solutions à long terme;

que de nombreux Canadiens, particulièrement des personnes ayant occupé des fonctions de premier répondant, de pompier, de militaire, d'agent correctionnel ou de membre de la Gendarmerie royale du Canada, sont atteints d'un état de stress post-traumatique et bénéficieraient grandement de l'élaboration et de la mise en œuvre d'un cadre fédéral relatif à l'ESPT qui viserait les pratiques exemplaires, la recherche, l'éducation, la sensibilisation et le traitement,

Now, therefore, Her Majesty, by and with the advice and consent of the Senate and House of Commons of Canada, enacts as follows:

Short Title

Short title

1 This Act may be cited as the *Federal Framework on Post-Traumatic Stress Disorder Act*.

Interpretation

Definitions

2 The following definitions apply in this Act.

Agency means the Public Health Agency of Canada. (*Agence*)

federal framework means a framework to address the challenges of recognizing the symptoms and providing timely diagnosis and treatment of post-traumatic stress disorder. (*cadre fédéral*)

Minister means the Minister of Health. (*ministre*)

Federal Framework on Post-Traumatic Stress Disorder

Conference

3 The Minister must, no later than 12 months after the day on which this Act comes into force, convene a conference with the Minister of National Defence, the Minister of Veterans Affairs, the Minister of Public Safety and Emergency Preparedness, provincial and territorial government representatives responsible for health and stakeholders, including representatives of the medical community and patients' groups, for the purpose of developing a comprehensive federal framework in relation to

(a) improved tracking of the incidence rate and associated economic and social costs of post-traumatic stress disorder;

(b) the establishment of guidelines regarding

(i) the diagnosis, treatment and management of post-traumatic stress disorder, and

(ii) the sharing throughout Canada of best practices related to the treatment and management of post-traumatic stress disorder; and

Sa Majesté, sur l'avis et avec le consentement du Sénat et de la Chambre des communes du Canada, édicte :

Titre abrégé

Titre abrégé

1 *Loi sur le cadre fédéral relatif à l'état de stress post-traumatique*.

Définitions

Définitions

2 Les définitions qui suivent s'appliquent à la présente loi.

Agence L'Agence de la santé publique du Canada. (*Agency*)

cadre fédéral Cadre visant à surmonter les difficultés que posent la reconnaissance des symptômes de l'état de stress post-traumatique et l'établissement rapide de son diagnostic et de son traitement. (*federal framework*)

ministre Le ministre de la Santé. (*Minister*)

Cadre fédéral relatif à l'état de stress post-traumatique

Conférence

3 Au plus tard douze mois après la date d'entrée en vigueur de la présente loi, le ministre convoque une conférence avec le ministre de la Défense nationale, le ministre des Anciens Combattants, le ministre de la Sécurité publique et de la Protection civile, des représentants responsables de la santé des gouvernements provinciaux et territoriaux et des intervenants, notamment des représentants de la communauté médicale et des groupes de patients, dans le but d'élaborer un cadre fédéral global qui porte sur ce qui suit :

a) l'amélioration du suivi de l'évolution du taux d'incidence et des coûts économiques et sociaux liés à l'état de stress post-traumatique;

b) l'établissement de lignes directrices concernant :

(i) le diagnostic, le traitement et la gestion de l'état de stress post-traumatique,

(c) the creation and distribution of standardized educational materials related to post-traumatic stress disorder, for use by Canadian public health care providers, that are designed to increase national awareness about the disorder and enhance its diagnosis, treatment and management.

(ii) la mise en commun à l'échelle nationale des pratiques exemplaires en matière de traitement et de gestion de l'état de stress post-traumatique;

c) la création et la distribution de matériel didactique normalisé portant sur l'état de stress post-traumatique, à l'intention des fournisseurs de soins de santé au Canada, en vue de mieux faire connaître cet état à l'échelle nationale et d'en améliorer le diagnostic, le traitement et la gestion.

Preparation and tabling of report

4 (1) The Minister must prepare a report setting out the federal framework and cause a copy of the report to be laid before each House of Parliament within 18 months after the day on which this Act comes into force.

Publication of report

(2) The Minister must publish the report on the Agency's website within 30 days after the day on which it is laid before a House of Parliament.

Établissement et dépôt d'un rapport

4 (1) Le ministre établit un rapport énonçant le cadre fédéral et il en fait déposer un exemplaire devant chaque chambre du Parlement dans les dix-huit mois suivant la date d'entrée en vigueur de la présente loi.

Publication du rapport

(2) Le ministre publie le rapport sur le site Web de l'Agence dans les trente jours suivant la date de son dépôt devant l'une ou l'autre chambre.

Review and Report

Review

5 The Agency must

(a) complete a review of the effectiveness of the federal framework no later than five years after the day on which the report referred to in section 4 is published; and

(b) cause a report on its findings to be laid before each House of Parliament within the next 10 sitting days after the review is completed.

Examen et rapport

Examen

5 L'Agence :

a) effectue un examen de l'efficacité du cadre fédéral dans les cinq ans suivant la date de la publication du rapport prévu à l'article 4;

b) fait déposer un rapport sur ses conclusions devant chaque chambre du Parlement dans les dix premiers jours de séance de celle-ci suivant la fin de l'examen.

REPORT OF THE COMMITTEE

Monday, June 11, 2018

The Standing Senate Committee on National Security and Defence has the honour to present its

EIGHTEENTH REPORT

Your committee, to which was referred Bill C-211, An Act respecting a federal framework on post-traumatic stress disorder, has, in obedience to the order of reference of Thursday, May 3, 2018, examined the said bill and now reports the same without amendment but with certain observations, which are appended to this report.

Respectfully submitted,

GWEN BONIFACE

Chair

OBSERVATIONS
to the EIGHTEENTH REPORT Report of the Standing Senate Committee on National Security and Defence
(Bill C-211)

- The bill's sponsor, Todd Doherty, MP (Cariboo—Prince George), told your committee that the exclusion of various occupations from the preamble to the bill was an accidental oversight and that he had intended to be as inclusive as possible. Your committee shares Mr. Doherty's view that the conference and federal framework should be as inclusive as possible.

- Your committee would like to ensure that health care providers and individuals in other high-stress occupations be asked to participate in developing the federal framework on post-traumatic stress disorder that is proposed in the bill. Your committee wishes to emphasize that the words "in particular" in the fourth paragraph of the bill's preamble indicate that the conference and the federal framework on post-traumatic stress disorder should include not only first responders, firefighters, military personnel, corrections officers and members of the Royal Canadian Mounted Police, but also a wide range of occupations whose members are affected by post-traumatic stress and related problems, including nurses, psychologists and other health care providers and first responders.

- Your committee shares the concern expressed by officials from the Canadian Psychological Association regarding clause 3(b)(i) that addresses the development of guidelines. This clause states that the conference aiming to establish a federal framework on post-traumatic stress disorder focus, among other topics, on "the establishment of guidelines regarding the diagnosis, treatment and management of post-traumatic stress disorder." Representatives of the Canadian Psychological Association stated that developing guidelines in this regard is the responsibility of health professionals and their associations, accreditors and regulators, not the government. Your committee therefore suggests that the conference on the federal framework on post-traumatic stress disorder promote the establishment and dissemination of guidelines, rather than developing them as such, as recommended by the Canadian Psychological Association.

- Your committee would like to ensure that the full range of mental health conditions obtained from high-stress occupations are considered in the development of the federal framework on post-traumatic stress disorder that is proposed in the bill. Your committee therefore advises that the conference on the federal framework on post-traumatic stress disorder consider the use of the term "operational stress injury." This term includes post-traumatic stress disorder, but also includes conditions like occupation-linked depression, anxiety disorders, adjustment disorder and the full range of substance disorders that people may face as a result of being in a high-stress work environment.

- Your committee is concerned that the current wording of Bill C-211 could imply that the national framework on post-traumatic stress disorder should only focus on cases that manifest as a direct consequence of the demands of their occupation. However, many cases of work-related cases of post-traumatic stress disorder are directly linked to cases of sexual misconduct and harassment. Your committee therefore suggests that the conference on the federal framework on post-traumatic stress disorder include these cases in its development of the national framework.

APPENDIX B

OTHER POPULATIONS AFFECTED BY PTSD

Survivors of physical, sexual and/or psychological violence

Survivors of physical, sexual and/or psychological violence may experience PTSD. Victimization rates are higher for certain groups such as women, Indigenous people, persons experiencing homelessness, and those who are LGBTQ2. Children and youth are especially vulnerable to violence and have a higher risk of mental health conditions in adulthood. For example, a study of sexually abused children who were followed over 40 years showed that women who were sexually abused during childhood were over seven times more likely to be diagnosed with PTSD.[48]

Survivors of disasters

Disasters can occur at any time, often with limited or no warning at all. Disasters can be natural, such as wildfires, earthquakes, tornadoes, floods; or human made, such as acts of terrorism, motor vehicle crashes, and house fires. Disaster survivors may experience a tremendous sense of loss especially if they have been injured or have lost loved ones, shelter, and/or employment. Individuals who experience disasters may be at increased risk of developing PTSD.[49] In the first year post-disaster, the prevalence of PTSD among disaster survivors ranges between 30% and 40%.[50]

Indigenous Populations[d]

There is very little research available on the prevalence of PTSD in First Nations, Inuit and Métis communities.

To understand trauma in Indigenous communities we must consider the effects of colonization, including the residential school experience, and the resulting intergenerational trauma experienced by multiple generations across Canada. For example, a study conducted in 2003 investigating the mental health status of 127 former residential school students in British Columbia found that 64% met the diagnostic criteria for PTSD.[51]

Historical, intergenerational, and ongoing forms of trauma increase risk factors that can impact the mental health of Indigenous Peoples, and increase risks of developing PTSD.[45, 46] For example, compared to non-Indigenous Canadians, First Nations, Inuit and Métis Peoples experience significantly higher rates of social health challenges such as lower educational attainment and employment levels and living in poverty. There is also more intimate partner violence reported by Indigenous Peoples compared to non-Indigenous people and the incidence of childhood sexual and physical abuses is much higher than other cultural groups. Indigenous Peoples are also more likely to experience stressful experiences in adulthood compared to the population at large, including violence, homicide, assault, and witnessing traumatic events.[51]

Additionally, Indigenous Peoples often encounter systemic racism and discrimination in many different systems where they access services (e.g., health care, education system). The current systems are created from a non-Indigenous worldview and are often experienced as alienating and unwelcoming. Feelings of mistrust in service providers and systems of care are commonly reported and are by-

[d] First Peoples Wellness Circle Policy Brief on PTSD: https://11d19480-8ac9-4dee-a0f8-02f67b6947c6.filesusr.com/ugd/0265ae_ec211634a1b04691aadf6ae72ab7dc1b.pdf

products of culturally unsafe care. Culturally unsafe systems of care may trigger historical memories, affect health-seeking behaviours, and prolong intergenerational trauma at an individual and collective level.[52]

LGBTQ2

LGBTQ2 youth and adults experience higher rates of victimization, trauma, and PTSD compared to heterosexual/cisgender youth and adults.[53] Additionally, gender nonconformity (gender expression that does not conform with the traits or conventional norms typically associated with their sex assigned at birth) increases the risk of abuse and PTSD symptoms due to stigma and discrimination.[54] Studies have found evidence of an association between discrimination linked with one's gender identity and/or expression and symptoms of PTSD, even when adjusting for other known sources of trauma.[55,56,57,58]

Refugees and other newcomers

The rates of mental health conditions in adult newcomers are significantly lower compared to other Canadians; however, rates may increase over time due to stress and uncertainty during the settlement process.[59]

Some refugees arrive in Canada bearing psychological trauma from their experiences witnessing and/or surviving acute violence and/or war.[59] Exposure to violence and trauma can also increase the risk of mental disorders, including PTSD, which may manifest over a period of time following their arrival. A meta-analysis of 20 studies that included 6,743 adult refugees who resettled in developed countries, the current prevalence rate of PTSD in refugees was 9%.[60] PTSD is also thought to be the most common mental health condition among children and youth exposed to war and violence.[61,62,63] Refugee children and youth have been shown to have ten times higher rates of PTSD than non-refugee children in the general population.[64]

The mental health of refugee children has also been associated with the severity of PTSD experienced by their caregivers, which adds complexity to treatment and recovery.[65] Newcomers also face challenges accessing mental health supports and services due to lack of awareness, language, and cultural barriers.

People experiencing homelessness

The causal pathways to PTSD in people experiencing homelessness are especially complex. PTSD can be a precursor to or the result of homelessness. This interactive relationship may be due to the higher likelihood of exposure to trauma while experiencing homelessness, such as robbery or assault. Losing a stable shelter, experiencing food insecurity and living in ongoing stressful conditions can also be perceived as traumatic. People experiencing homelessness are also at an elevated risk of substance-related harms. In a British Columbia study of 489 participants who were living in a shelter or on the street, 100 individuals (20.5%) met the criteria for PTSD and, 92% of whom had a concurrent substance use disorder.[66]

APPENDIX C

CURRENT PTSD INITIATIVES IN CANADA

There is a wide range of initiatives offered by government, non-government organizations, and non-profit organizations that provide services and support to people affected by trauma and PTSD. Some are longstanding and others more recent. The variety and diversity of these initiatives is an indication of the collective commitment and understanding in Canada that resources and efforts must be dedicated at many levels to support all those affected by PTSD.

The wide range of current initiatives is an indication of the value of comprehensive approaches adaptable to various communities and cultures, including First Nations, Inuit and Métis cultures, as well as the need for initiatives and interventions that are offered across a continuum from raising awareness and building resiliency, to effective and timely access to evidence-based treatments.

TABLE 1: Intervention continuum for trauma exposure

Interventions designed to promote positive mental health, wellness, and resilience	EXPOSURE TO TRAUMA	**Interventions designed to provide support following a traumatic event**	**Clinical, evidence-based interventions to treat PTSD**
When: Ongoing		**When:** May be immediate, or in the weeks and months, following exposure to a traumatic event	**When:** As soon as possible following diagnosis
Who: All individuals		**Who:** All individuals exposed to a traumatic event, as well as the people who support them, who may or may not be experiencing symptoms of stress	**Who:** Specific individuals who have received a PTSD diagnosis
Activity type ▸ Education programming or content (e.g., *Road to Mental Readiness [R2MR]*) ▸ Resiliency or Pre-Event training for higher-risk occupations and events (e.g., Before Operational Stress) ▸ Stigma reduction and awareness campaigns ▸ Mental health plans and supports (including employee assistance programs)		**Activity type** ▸ Mental health first aid ▸ Peer support ▸ Incident response and support ▸ Employee assistance programs	**Activity type** ▸ Individual trauma-focused therapies (e.g., prolonged exposure therapy, cognitive processing therapy, eye movement desensitization and reprocessing [EMDR]) ▸ Pharmacotherapy ▸ Adjunct, supportive and emerging interventions (e.g., yoga, meditation, relaxation, behavioural activation, group and couple-based trauma treatment, land-based healing, service dogs)
Supported by research, frameworks, policies, legislation, etc.			

The following overview of PTSD initiatives provided by government and key stakeholders and partner organizations is not exhaustive, but is intended to showcase the breadth and depth of existing initiatives.

Federal government

The Government of Canada works to improve the mental health and wellbeing of all Canadians. The federal government is also the country's single largest employer and offers multiple initiatives to support the mental health of its workforce, which is spread across the country and around the world and includes a range of occupations.

There are federal initiatives that specifically support those living with PTSD, people at risk of developing PTSD and their family and support networks. They include research, data gathering, knowledge development, awareness, proactive protection and resiliency training, sharing best practices, support for employees, and in some case, the direct delivery of care for populations under federal jurisdiction.

Canadian Armed Forces Members and Veterans

The mental health programs for Canadian Armed Forces (CAF) members, Veterans, their loved ones and communities, include a range of services to build positive mental health, as well as help for those affected by operational stress injuries (OSI), including, but not limited to, PTSD. For example, in the CAF-VAC Joint Suicide Prevention Strategy there are over 160 actions[e] underway or under development in the areas of education and health promotion, national peer support, clinical care and psychosocial services. Research programs are also in place to better understand the mental health burden in CAF members, Veterans, and their loved ones, and what type of programming best addresses their well-being.

Programs and services provided by the CAF include:

- Specialized mental health services for ill and injured members of the CAF at 31 medical clinics across Canada, including seven Operational Trauma and Stress Support Centres (OTSSCs).
- CAF and VAC jointly sponsor the Operational Stress Injury Social Support (OSISS) service, a national peer support network serving CAF members and Veterans and their families affected by an OSI.
- The Member Assistance Program (MAP) for CAF members offers confidential, short-term counselling for any issue. (In partnership with Health Canada).
- The Road to Mental Readiness (R2MR) training, which is intended to increase early awareness of distress, encourage care-seeking, normalize mental health challenges, and provide evidence-based skills to manage the demands of service and daily life.
- Operation HONOUR is the CAF's mission to eliminate sexual misconduct in the Canadian military by supporting people affected by sexual misconduct, developing procedures, programs and policies for affected individuals and the chain of command and preventing sexual misconduct from occurring through increased understanding of the issue, training and education programs.

[e] https://www.canada.ca/content/dam/dnd-mdn/documents/reports/2017/caf-vac-joint-suicide-prevention-strategy.pdf

Programs and services sponsored by VAC:

- A national network of Operational Stress Injury Clinics, specialized in providing mental health care to CAF Veterans, RCMP members, and CAF serving members impacted by an OSI.
- Free online and mobile applications such as PTSD Coach Canada and OSI Connect.
- VAC Assistance Service for Veterans, former RCMP members, their families, and caregivers, which offers confidential counselling for any issue. Pastoral support is available for those who would like to receive support from a member of the clergy. (In partnership with Health Canada).
- Support for the Canadian Institute for Military and Veteran Health Research (CIMVHR).
- Support for a Centre of Excellence on PTSD and Related Mental Health Conditions. The mission of the Centre is to increase Canadian expertise about Veteran and military OSIs (including but not limited to PTSD) and to make the expertise accessible to health care providers, people with lived experience, family members and support networks, researchers and the Canadian public.
- Support for a new Centre of Excellence on Chronic Pain in Veterans. Chronic physical health conditions and chronic pain frequently co-occur with mental health conditions in Veterans. The mission of this Centre of Excellence is to increase Canadian expertise about chronic pain

In 2018, Statistics Canada conducted a Mental Health Follow-up Survey in collaboration with the CAF, VAC and the University of Manitoba. The purpose of the survey was to re-assess the mental health of respondents who participated in a similar survey conducted in 2002. Results of the 2018 Canadian Armed Forces Members and Veteran Mental Health Follow-up Survey are now available (https://www150.statcan.gc.ca/n1/daily-quotidien/190423/dq190423d-eng.htm).

Public safety personnel

With support from the Canadian Institutes of Health Research (CIHR) and Public Safety Canada, an online survey of Canadian public safety personnel was conducted from September 2016 to January 2017 to provide estimates of mental disorder symptom frequencies and severities in this population. The survey assessed current symptoms, and participation was solicited from national public safety personnel agencies and advocacy groups. In total, 5,813 participants took part in the survey (32.5% women) and were grouped into six categories (i.e., call centre operators/dispatchers, correctional workers, firefighters, municipal/provincial police, paramedics, and RCMP). The results were released in 2018.[21]

Supporting Canada's Public Safety Personnel: An Action Plan on Post-Traumatic Stress Injuries (PTSI), released on April 8, 2019 recognizes that, while public safety personnel work in multiple jurisdictions, each with their own responsibilities for providing mental health supports, there is a clear and urgent need for country-wide leadership on the challenges they all face. The Action Plan aims to strengthen the collective understanding of PTSI through research (including applied research and treatment trials); to support mental health resilience through evidence-based research to inform public awareness, training, and other initiatives that emphasize prevention, early intervention and stigma reduction; and to identify ways public safety personnel organizations can better monitor and manage the mental health of public safety personnel through support for care and treatment.

The Action Plan includes 16 key actions to complement recent initiatives and actions by the Government of Canada to support research, training, and treatment and advance the ability to make evidence-based decisions, including:

- A new national research consortium between CIHR and the CIPSRT to address PTSI among public safety personnel. The research is focusing on understanding, identifying, mitigating and/or preventing PTSI and adverse mental health outcomes for public safety personnel. CIPSRT will act as the national research consortium's knowledge exchange hub, bringing together relevant stakeholders to mobilize the knowledge created into active use.
- The development of an Internet-based Cognitive Behavioural Therapy Pilot to provide greater access to care and treatment of public safety personnel, particularly those in rural and remote areas.
- The RCMP Longitudinal Study on PTSD is an innovative and unique multi-year research project to investigate the effects of policing on the mental health of RCMP members and assess the benefits of a specialized, skills-based mental health training program. The ultimate goal of the study is to develop a skills-based training system for mental health that reduces risk, increases resilience, and enhances treatment efforts. RCMP cadets who participate will provide important data about their physical and mental health, beginning in their earliest days of training, and then throughout their first five years as RCMP officers. The findings of this study will help develop appropriate mental wellness and remedial strategies for the RCMP, and also inform the approaches of other emergency response organizations. RCMP cadet participation in the study began in April 2019.
- Building on successes from the CAF, R2MR training is being adapted to public safety personnel groups across government, including border services personnel, federal corrections officers, RCMP, and operational and intelligence personnel.

In partnership with Public Safety Canada, Defence Research and Development Canada's (DRDC) Centre for Security Science (CSS) works to strengthen Canada's ability to anticipate, prevent/mitigate, prepare for, respond to, and recover from acts of terrorism, crime, natural disasters, and serious accidents through the convergence of Science and Technology with policy, operations, and intelligence. As part of this work, DRDC funds projects that work to inform the current and future needs of Canadian public safety personnel through the development of specific health and wellness standards and through research into health and wellness models of care.

The Canadian Security Intelligence Service (CSIS), Canadian Border Services Agency and the RCMP also provide training, protocols, and support programs for employees in positions at high risk of exposure to offensive and abhorrent material.

Canadian Coast Guard employees

The Canadian Coast Guard (CCG) has developed a Trauma Resilience Training Program to acknowledge and address the needs of CCG and Department of Fisheries and Oceans (DFO) operational employees who are suffering from, or may suffer from OSI, trauma and PTSD. The risk of being impacted by traumatic events among Coast Guard employees is considered to be high and this training module is used as a means of building resilience through pre-incident awareness and tools to help employees cope when incidents occur. The intention of trauma resilience training is to create a more trauma-informed organization, de-stigmatize trauma reactions, and prevent traumatization.

All federal employees

Employee Assistance Services (EAS), Health Canada, has developed and trained a Psychosocial Emergency Response Team. This team of trauma professionals from across Canada is available, upon request, to assist federal departments and agencies to manage the psychological and social response and recovery activities when a major traumatic event occurs in the workplace. This team has been deployed to events such as the Lac Mégantic rail disaster and the Toronto Young Street van attack.

The EAS also provides Pre-Event training, which focuses on understanding and categorizing stress types and common reactions to excessive stress emphasizing the range of tools required to manage stress and create resiliency.

Federal departments with employees at higher risk of exposure to traumatic events have additional tools such as Critical Incident Stress Management (CISM) Programs, which provide psychosocial support before, during and after a disaster event or critical incident. For example, Correctional Service Canada provides the CISM program to all employees, the Department of Fisheries and Oceans offers CISM to Coast Guard, Protection and Conservation Officers, and Health Canada has a CISM program that provides prevention and response-oriented services for nurses (federal and band-transferred) working in remote First Nations communities.

The federal government also has a suite of tools and resources to support employees with mental health issues. These include: employee assistance programs that provide access to mental health care providers (including support for traumatic events); disability management; return to work; duty to accommodate programs; and workers' compensation benefits for occupational injuries and illnesses.

In 2016, the federal government adopted the Federal Public Service Workplace Mental Health Strategy which requires federal departments to develop comprehensive action plans on mental health. As a result, many have adopted a holistic approach to health and wellness, focused on physical and psychological wellbeing of employees through prevention, promotion and intervention and de-stigmatization of mental health issues in the workplace. This includes the adoption of the *National Standard for Psychological Health and Safety in the Workplace.*

Indigenous Populations

The Indian Residential Schools Resolution Health Support Program, and Missing and Murdered Indigenous Women and Girls (MMIWG) Health Support Services work with individuals, families and communities as they heal from unresolved and intergenerational trauma rooted in their Residential School experience or loss and grief related to MMIWG, through cultural and emotional supports, as well as access to trauma-informed and culturally-safe mental health counselling.

Refugees and other newcomers

Through its Settlement Program, Immigration, Refugees and Citizenship Canada funds service provider organizations to deliver non-clinical mental health-related supports and provide community-based health information for newcomers. The Department also supports capacity building of service providers so they can respond to the needs of vulnerable groups, particularly women, youth, seniors, and refugees.

The Interim Federal Health Program offers limited, temporary health care coverage to resettled refugees, asylum seekers, and other groups, such as victims of human trafficking, and persons detained under the *Immigration and Refugee Protection Act*, until they become eligible for provincial or territorial health care coverage or, in the case of asylum claimants, leave Canada. This coverage includes a wide range of mental health supports provided by general practitioners, psychiatrists, psychologists, registered psychotherapists, registered counselling therapists, and licensed social workers. Coverage is also provided for prescription drugs, as well as interpretation and translation during counselling sessions.

All Canadians

The Public Health Agency of Canada (PHAC) works to reduce cross-cutting risk factors for mental health issues – including PTSD – such as violence, discrimination, stigma and other forms of trauma that can have lasting impacts on both mental and physical health. PHAC has made strategic investments in community-based projects to improve the physical and mental health of those who have experienced the trauma of family violence. PHAC also led the development of the *Federal Framework for Suicide Prevention*, published in 2016, which sets out the Government of Canada's guiding principles and strategic objectives in suicide prevention. This initiative is helping to raise awareness and reduce stigma, better connect people to information and resources, and accelerate innovation and research in suicide prevention.

The Government of Canada invests via the Canadian Institutes of Health Research (CIHR) in research on mental health and behavioural conditions such as PTSD, PTSI, suicide, and substance use. CIHR investments in mental health research and behavioural condition research are building the evidence base needed to inform policy-makers and clinicians on how to deliver the most effective mental health services for Canadians, including those living with and impacted by PTSD.

As part of its 2017 Health Accord with provinces and territories, the federal government invested more than $5 billion over ten years in mental health services based on shared principles and health priorities. Additional investments through the Emergency Treatment Fund were rolled out to provinces and territories to deal with an acute need for immediate care and treatments for individuals with substance use disorders.

Statistics Canada collects, analyzes and provides high-quality statistical information on a range of relevant topics that increase our understanding of PTSD, including those related to health, justice, social wellbeing, and special populations. The Statistics Canada Population Health Program collects information on diagnosed chronic conditions in the general population, including mood and anxiety disorders. In partnership with other relevant stakeholders, the Centre for Population Health Data is exploring how Statistics Canada can develop a new suite of projects related to the mental health of Canadians. An initiative to expand the relevance of population health data integrates existing survey data that includes information on PTSD diagnosis to administrative health records and information from the Census.

Other partners and stakeholders who provide PTSD support and services

Mental Health Commission of Canada (MHCC)

The MHCC is a pan-Canadian health organization, funded by the Government of Canada. The MHCC leads the development and dissemination of innovative programs and tools to support the mental health and wellness of Canadians.

The MHCC has played a leadership role in building capacity to advance the mental health of public safety personnel. Through stakeholder collaboration, the MHCC has developed and adapted training tools and resources to enable organizations to adopt comprehensive mental wellness strategies. The Working Mind First Responders, adapted from the CAF Road to Mental Readiness Training, is designed to reduce the stigma of mental illness and address and promote mental health and resiliency in a public safety workplace setting. The Program includes a self-assessment tool and a set of evidenced-based, cognitive behavioural therapy techniques that help individuals cope with stress and improve their mental health and resiliency.

The MHCC also offers its Mental Health First Aid (MHFA) training, at a cost, across Canada. MHFA teaches participants to recognize the signs and symptoms of the most common mental health conditions so they can support individuals who may be showing early signs of a mental health problem or crisis and direct them to appropriate support services.

The MHCC has an educational video series, which showcases stories of individual Canadian public safety personnel from coast to coast who have experienced and overcome mental health challenges, including PTSD. During the past decade, the MHCC has reduced stigma among a variety of target groups (e.g., youth, health care providers, the workforce, and news media and first responder stigma toward opioid users) through its program Opening Minds.

Canadian Institute for Public Safety Research and Treatment (CIPSRT)

CIPSRT's mission is to provide a Canadian knowledge exchange hub for strategic public safety wellness research and analysis by working with public safety leaders and academics from across Canada to translate and mobilize research knowledge that meets the current and future needs of Canadian public safety personnel, their leadership, and their families. Through its national network, CIPSRT responds to the identified needs of public safety personnel by producing or facilitating the evidence necessary for engaging strategies and allocating resources to support high-quality and easily accessible mental health care for all public safety personnel. CIPSRT works to improve the lifetime health and wellbeing of people directly or indirectly related to public safety personnel, including frontline personnel, support personnel, families of personnel, and retired personnel. CIPSRT research focuses on the unique occupational exposures, experiences, and environment encountered by people directly or indirectly related to public safety personnel.

Canadian Institute for Military and Veteran Health Research (CIMVHR)

CIMVHR brings together a network of 43 Canadian university members, ten global affiliates, four philanthropic organizations, three industry partners, several government departments, and more than 1,700 researchers—who are all committed to improving the way that Canada cares for members of the military, Veterans, and their families. As the Canadian hub for military, Veteran and family health

research, CIMVHR provides the infrastructure to enable more of Canada's military, Veteran, and family health research requirements to be met by enhancing the accessibility of military, Veteran, and family health research; and engaging with stakeholders to foster collaborations, which enables increased research and improves knowledge translation activities.

CIMVHR also hosts an annual forum to engage thought leaders from government, academia, industry and philanthropic sectors. Issues discussed at the forum include mental disorders, such as PTSD, prevention and treatment of chronic health conditions, suicide prevention, and the transition to civilian life. Since 2018, CIMVHR has collaborated with CIPSRT to include research related to public safety personnel on the agenda. The forum provides an important opportunity for participants to present new research, exchange ideas, share insight, learn and collaborate on the needs of military, Veterans, public safety personnel, and their families.

Provinces and territories

All provinces and territories have mental health strategies, which focus on upstream approaches to mental health care, mental health services, stigma reduction, and treatment. These strategies recognize the impacts of trauma (including intergenerational and historical trauma) on mental health and as a risk factor for substance-related harms and suicide.

Many provinces and territories recognize the impact of PTSD on their workforce and have implemented presumptive legislation for PTSD. Presumptive legislation links a disease or condition that has been evidenced as a hazard associated with a particular occupation and allows for more timely access to services and benefits if diagnosed with the disease or condition.

As of September 2019, presumptive legislation for occupational mental health claims existed in all jurisdictions across Canada aside from Quebec, the Northwest Territories, and Nunavut. While this type of legislation is limited to PTSD in most jurisdictions, they apply to a broader set of psychological injuries in British Columbia, Alberta, Saskatchewan, and Prince Edward Island. Occupations covered by this type of legislation range from first responders (police, firefighters, paramedics) in New Brunswick and the Yukon to public safety personnel (often including correctional officers, nurses, and dispatchers) in British Columbia, Ontario, and Nova Scotia to all occupations in Alberta, Saskatchewan, Manitoba, Prince Edward Island, as well as Newfoundland and Labrador.

Alberta, Ontario, British Columbia, Saskatchewan, and Yukon offer formal support programs for jurors, which allows at least four free counselling sessions if necessary, following a trial. Most other provinces and territories have mechanisms in place to provide support for jurors, but not through a formalized program and the level of support varies by jurisdiction.

Two provinces introduced legislation designating June 27 as PTSD awareness day--Alberta celebrated its first PTSD awareness day on June 27, 2016 and Ontario began in 2019. This day was established to bring awareness to the issue, reduce stigma and recognize those living with PTSD, and the value of lived experience.

Indigenous Organizations

First Nations Mental Wellness Continuum Framework

The *First Nations Mental Wellness Continuum Framework* (FNMWCF) is a national framework that addresses mental wellness among First Nations in Canada. This framework was developed collaboratively by the Assembly of First Nations, Health Canada's former First Nations and Inuit Health Branch, the National Native Addictions Partnership Foundation, the Native Mental Health Association, and other community mental health leaders.

The FNMWCF is designed to strengthen federal mental wellness programs and appropriately integrate federal, provincial, and territorial programs. The FNMWCF also guides communities to better plan, implement, and coordinate comprehensive responses to mental wellness challenges in ways that are consistent with community priorities.

The FNMWCF is organized around five key themes: culture as a foundation; community development ownership and capacity building; quality care system and competent service delivery; collaboration with partners; and, enhanced flexible funding.[67]

The National Inuit Suicide Prevention Strategy

Launched in 2016 by Inuit Tapiriit Kanatami (ITK), the *National Inuit Suicide Prevention Strategy* (NISPS) has set out a series of actions and interventions to reduce the high rates of suicide among Inuit. The Strategy promotes a shared understanding of the context and underlying risk factors for suicide in Inuit communities and guides policy at the regional and national levels on evidence-based approaches to suicide prevention.[68]

The NISPS outlines six priorities areas for action and investment: create social equity; create cultural continuity; nurture healthy Inuit children; ensure access to continuum of mental wellness services for Inuit; heal unresolved trauma and grief; and mobilize Inuit knowledge for resilience and suicide prevention.

Although the Strategy focuses on suicide prevention and reducing risk factors, it also intends to build overall resilience and increase protective factors that impact mental wellness. In the priority area related to, "Healing Unresolved Trauma and Grief," the Strategy aims to address the current and ongoing impacts of historical and intergenerational trauma, as well as traumatic losses from suicide and other tragic events. The specific objectives of this priority area include the development of Inuit-specific approaches and resources and services to first responders within communities who may be impacted by exposure to the aftermath of suicide and suicide attempts.

APPENDIX D

GLOSSARY OF TERMS

A SHARED UNDERSTANDING OF THE COMMON TERMS USED TO DESCRIBE PSYCHOLOGICAL TRAUMA

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CIPSRT
Canadian Institute for Public Safety Research and Treatment

ICRTSP
Institut canadien de recherche et de traitement en sécurité publique

Glossary of terms: A shared understanding of the common terms used to describe psychological trauma (version 2.0).

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(CIPSRT, 2019)

Preamble

Post-traumatic stress disorder (PTSD) is a potentially disabling condition that is now a widely recognized public health issue, particularly among *public safety personnel (PSP)*. A recent study conducted by Carleton et al. (2018) investigated the proportion of Canadian *PSP* reporting symptom clusters consistent with various *mental disorders*. The results indicated that 23.2% of the total sample screened positive for *PTSD* (in contrast, estimates of the prevalence of *PTSD* among the general population range from 1.1 to 3.5%). *PTSD* and other mental disorders are concerning for all Canadians; nevertheless, the Federal Framework on Post-traumatic *Stress* Disorder Act was introduced to address the "clear need for persons who have served as first responders, firefighters, military personnel, corrections officers and members of the RCMP to receive direct and timely access to *PTSD* support." The Act called for the creation of a federal framework on *PTSD*. The Public Health Agency of Canada (PHAC) was mandated to lead the implementation of the Act. Early on, the need for a glossary of terminology around *psychological trauma* became clear and, in collaboration with PHAC and other partners, the Canadian Institute for Public Safety Research and Treatment (CIPSRT) led the development of the glossary.

Assembling a glossary of terms that describes *mental health* and *mental health conditions* is a significant challenge. No universally accepted list works for every person and every situation. Words used to describe *mental health* and *mental health conditions* have different meanings for different people in different contexts. Therefore, there is a need for a glossary that makes the evolving language of *PTSD* and related terms accessible to everyone. Such a resource provides a common language that various stakeholders (e.g., researchers, health professionals, *PSP*) can use to communicate more effectively.

Health professionals use words very carefully to describe the signs, symptoms, and *diagnoses* of *mental disorders*. Careful use of language helps professionals to summarize complex sets of signs and symptoms, connecting patients with treatments most likely to help them. Careful use of language also helps researchers working to develop better tools for assessment, treatment, *diagnosis*, and prevention. The *Diagnostic* and Statistical Manual of Mental Disorders (DSM; American Psychiatric Association, 2013) and the International Classification of Diseases (ICD; World Health Organization, 2018) each provide widely used criteria for diagnosing *mental disorders*.

The language used to describe various aspects of *mental health* and *mental health conditions* is continuously being refined. The definitions we offer in the current version of the Glossary may not yet reflect unanimous consensus by the contributors to the current document, because in some cases there is significant debate about definitions; however, in all cases we have tried to provide the most balanced and collaborative definition possible. Currently, only four terms in the current glossary are *diagnostic* categories in the current editions of the DSM or ICD: *Burnout, Acute Stress Disorder (ASD), Posttraumatic Stress Disorder (PTSD),* and *Complex PTSD (C-PTSD)*. Many other related terms are currently in use, with varying degrees of support.

Separate definitions have been included for terms that are frequently used colloquially, many of which are often used inappropriately or could be subsumed within the definitions of other terms. Such terms have been included as part of an effort to help shift towards more accurate and less stigmatizing language. As the language shifts, we expect the less appropriate terms to drop from use. In the interim, suggestions have been made for alternative terms that would be more accurate or less stigmatizing, and in some cases we have explicitly recommended an alternative term because of historically inappropriate use, stigma, or confusion.

The use of language for *mental health* and *mental health conditions* often differs among professionals from various disciplines, and many words used in professional contexts have different meanings for people who are not health professionals. In addition, many cultural factors shape how we think about *mental health* and *mental health conditions* including values, preferences, clinical experience, and research results. For example, in recent years, the word "*injury*" has been used more often by many people to describe some *mental health conditions*, replacing the term "*disorder*," which has important meaning for health professionals. On the one hand, the word "*injury*" helps to diminish stigma that can accompany the term "*disorder*." On the other hand, the word "*disorder*" has a deep meaning for health professionals that communicates important information about a person's condition, functional limitations, and optimum treatment.

The current Glossary is intended to promote a shared understanding of many of the common terms that are used to describe *mental health* and *mental health conditions* arising in the context of exposure to potentially *psychologically traumatizing events* and *stressors*. The intent is part of an ongoing effort to bridge any gaps that may exist between health professionals and the diverse communities they serve. The current Glossary focuses on *Posttraumatic Stress Disorder* and closely related terms, but that should not be misinterpreted as indicating other *mental health conditions* that can be caused by exposure to one or more potentially *psychologically traumatic events*, such depression, anxiety, psychosis, substance related harms, and suicide, to name only a few, are less important. As the fields of *mental health* and *mental health conditions* are ever-changing; the current Glossary is a "living document" that will be revised over time to reflect new understandings.

Preamble References

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ACRONYMS

ASD	Acute *Stress* Disorder
ACE	Adverse Childhood Experiences
CAF	Canadian Armed Forces
CIMVHR	Canadian Institute for Military and Veteran Health Research
CIPSRT	Canadian Institute for Public Safety Research and Treatment
C-PTSD	Complex Posttraumatic *Stress* Disorder
DSM	*Diagnostic* and Statistical Manual of Mental Disorders
FNMWCF	First Nations Mental Wellness Continuum Framework
ICD	International Classification of Diseases
OSI	Operational *Stress* Injury
PTG	Posttraumatic Growth
PTS	Posttraumatic *Stress*
PTSD	Posttraumatic *Stress* Disorder
PTSI	Posttraumatic *Stress* Injury
PTSS	Posttraumatic *Stress* Syndrome
PHAC	Public Health Agency of Canada
PSP	Public Safety Personnel
VAC	Veterans Affairs Canada

A	*Acute Stress Disorder (ASD)* *Adverse Childhood Experiences (ACE)*
B	*Burnout*
C	*Compassion Fatigue* *Complex Posttraumatic Stress Disorder (C-PTSD)* *Complex Trauma* *Critical Incident*
D	*Diagnosis / Diagnostic*
F	*First Responder(s)*
H	*Health*
I	*Interpersonal Violence*
M	*Mental Disorder* *Mental Health* *Mental Health Injury / Psychological Injury* *Mental Health Condition/Mental Health Challenge* *Mental Illness* *Moral Injury*
O	*Occupational Stress Injury / Organizational Stress Injury* *Operational Stress Injury (OSI)*
P	*People with Lived Experience / Experts by Experience* *Posttraumatic Growth (PTG)* *Posttraumatic Stress (PTS)* *Posttraumatic Stress Disorder (PTSD)* *Posttraumatic Stress Injury (PTSI)* *Posttraumatic Stress Syndrome (PTSS)* *Psychological Trauma / Psychologically Traumatic Injury / Psychologically Traumatized* *Psychologically Traumatic Event / Psychologically Traumatic Stress / Psychologically Traumatic Stressor* *Public Safety Personnel (PSP)*
R	*Recovery* *Resilience*
S	*Stress / Stressor / Stressful Event*
T	*Trauma / Traumatic Injury* *Traumatic Event / Traumatic Stress / Traumatic Stressor* *Tri-Services*
V	*Vicarious Traumatic Stress* *Vicarious Traumatization*
W	*Well-being (Wellbeing)* *Wellness*

Words defined in this Glossary are shown in ***italics***.

The definitions in the Glossary are presented alphabetically.
For each term, we offer both a definition for experts and a plain language version.

Acute Stress Disorder (ASD)

For Experts

- *Diagnostic* criteria are provided for *ASD* in the DSM and ICD.
- A *mental disorder* that can occur after exposure to psychological *stressors* during one or more potentially *psychologically traumatic events* perceived as involving severe threat to self or others.
- Similar to *Posttraumatic Stress Disorder,* symptoms may include (but are not limited to):
  1. Recurrent involuntary memories or significant physiological reactions;
  2. Inability to feel positive emotions;
  3. Trouble remembering and avoidance of the *psychologically traumatic event*;
  4. Hyperarousal, and
  5. Sometimes persistent feelings of detachment.
- The experiences have lasted for three days or more but less than one month and cause clinically significant di*Stress* or impairment in social, occupational, or other important areas of functioning.
- The symptoms and signs are not better explained by another mental or physical *health* condition or the effects of a substance.
- Can evolve into *Posttraumatic Stress Disorder* and other types of *psychological trauma*.

For General Public

- *Diagnostic* criteria are provided for *ASD* in the DSM and ICD.
- A *mental disorder* that can happen after exposure to psychological *stressors* during specific types of severe, potentially *psychologically traumatic events*.
- Symptoms may include (but are not limited to): intrusive flashback memories of the event, inability to have positive feelings, trouble remembering the event, avoiding reminders of the event, disturbed sleep or being too vigilant, and sometimes feelings that things are unreal.
- Symptoms begin within one-month of experiencing the potentially *psychologically traumatic event* and may develop into *Posttraumatic Stress Disorder* after one month; however, *Acute Stress Disorder* is not a prerequisite for *Posttraumatic Stress Disorder*.
- The *diagnosis* of *Acute Stress Disorder* is made if the person's condition is not better explained by another physical or *mental disorder*.

Adverse Childhood Experiences (ACE)

For Experts

- "*Adverse childhood experiences* are defined operationally as childhood events, varying in severity and often chronic, occurring in a child's family or social environment that cause harm and di*Stress*, thereby disrupting the child's physical or psychological *health* and development" (Kalmakis & Chandler, 2014).
- Examples include, but are not limited to, exposure to emotional, physical or sexual abuse, emotional or physical neglect, intimate partner violence, or dysfunction within the household (e.g., exposure to parental separation, a family member with a history of *mental disorders*, substance use, incarceration, or suicide attempt).

For General Public

- Experiences of potentially *psychologically traumatic events* in a child's family or social life that disrupt the *health* of child causing harm or di*Stress*.
- Includes, but not limited to emotional or physical neglect, emotional, physical or sexual abuse, or violence in the household.
- Can predispose children to later life *mental health conditions*.

Burnout

For Experts

- Currently a *diagnosis* in the ICD.
- *Burnout* is described by the World Health Organization as an "occupational phenomenon" and is included in the International Classification of Diseases (ICD-11). The ICD-11 defines *Burnout* as "a syndrome conceptualized as resulting from chronic workplace *Stress* that has not been successfully managed." "Burn-out refers specifically to phenomena in the occupational context and should not be applied to describe experiences in other areas of life," (World Health Organization, 2018).
- It is a "psychological syndrome in response to chronic interpersonal *Stress*ors on the job. The three key dimensions of this response are an overwhelming exhaustion, feelings of cynicism and detachment from the job, and a sense of ineffectiveness and lack of accomplishment" (Maslach, Leiter and Schaufeli, 2009).
- Can also involve negative change in reaction to others, including depersonalization, inappropriate attitudes towards coworkers, irritability, loss of idealism, and withdrawal (Maslach, Leiter and Schaufeli, 2008).
- Perceived "high caseloads, lack of control or influence over agency policies and procedures, unfairness in organization structure and discipline, low peer and supervisory support, and poor agency and on-the-job training" have been identified as organizational factors underlying *Burnout* (Barak, Nissly & Levin, 2001; Maslach & Leiter, 1997; Newell & MacNeil, 2010).
- Distinct from *compassion fatigue, vicarious stress, and vicarious trauma,* because *Burnout* is not necessarily or exclusively related to exposures to potentially *psychologically traumatic events, complex trauma,* or *adverse childhood experiences.*

For General Public

- Currently a *diagnosis* in the ICD.
- A *mental health condition* that can occur when the person experiences ongoing *occupational stress* in the workplace, particularly *organizational stress* (e.g., ongoing conflict with supervisors or colleagues, high amounts of overtime; insufficient breaks).
- Might be occurring when the person seems to have one or more of the following: overwhelming exhaustion, is cynical, feels detached from the job, feels ineffective, or does not get rewards from working in the job.

Compassion Fatigue

For Experts

- Currently not a *diagnosis* in the DSM or ICD.
- A *mental health condition* describing adverse psychological reactions in persons providing care to others, which is related to the *Stress* experienced from caring, empathizing, and both the physical and psychiatric investments made when helping people who are suffering.
- *Compassion fatigue* can include a sense of helplessness, confusion, and a loss of compassion or empathy toward those one is treating or helping, as well as feelings of isolation from colleagues and usual social supports.
- *Compassion fatigue* can occur as a result of singular exposure or an accumulation of exposures to *trauma*.
- Sometimes associated with *vicarious stress* or *vicarious trauma*, but considered distinct from *Burnout*.

For General Public

- Currently not a *diagnosis* in the DSM or ICD.
- A type of *mental health condition* that can occur in caregivers.
- Related to the *stress* of caring about other people who are in di*Stress* or who are suffering.
- Creates a sense of helplessness, confusion, or a loss of compassion and empathy for others, and feelings of being isolated from colleagues and other people.

Complex Post-traumatic Stress Disorder (C-PTSD)

For Experts

- Currently a *diagnosis* in the ICD.
- Meets all the *diagnostic* requirements for *Posttraumatic Stress Disorder*, with additional criteria, as specified in the ICD.
- The main things that distinguish *C-PTSD* from *Posttraumatic Stress Disorder* are the protracted nature of the potentially *psychologically traumatic event* (e.g., exposure to a concentration camp), the subsequent distortions of the person's sense of self and core personal and social identity, and significant emotional dysregulation. *Posttraumatic Stress Disorder* is more typically associated with a discrete *traumatic event* or set of *traumatic events*.
- Described by Judith Herman (1992, 1995, 2015).

For General Public

- Currently a *diagnosis* in the ICD.
- A type of *Posttraumatic Stress Disorder* that results from repeated severe *traumatic events* that the person cannot escape usually as a result of *adverse childhood experiences*.
- People with the condition have a profound loss of sense of identity and great difficulty controlling their emotions.

Complex Trauma

For Experts

- Currently not a *diagnosis* in the DSM or ICD.
- *Psychological trauma* resulting from exposure to multiple *traumatic events* or a single prolonged *traumatic event*, particularly when the event was difficult to escape, such as repeated childhood sexual or physical abuse, prolonged domestic violence, torture, slavery, genocide campaigns (Greeson, Briggs, Kisiel, Layne, Ake, Ko, Gerrity, Steinberg, Howard, Pynoos, & Fairbank, 2011; Briere & Scott, 2015; National Child Traumatic *Stress* Network, 2019).
- Can result in *mental health conditions,* including but not limited to, *Posttraumatic Stress Disorder* and *C-PTSD,* depending on the severity of the response to the initial exposure.
- Often mistakenly used interchangeably with *C-PTSD,* but *Complex Trauma* would be a causal experience that may lead to *C-PTSD*.

For General Public

- Currently not a *diagnosis* in the DSM or ICD.
- Severe *psychological trauma* resulting from severe types of potentially *psychologically traumatic events*.
- Often used in conversations interchangeably with *C-PTSD*.

Critical Incident

For Experts

- Currently not a *diagnosis* in the DSM or ICD.
- Potentially *psychologically traumatic events* that are common among some groups, such as *public safety personnel*.
- *Critical incidents* were thought to involve experiencing unusually strong emotional reactions which have the potential to interfere with responders' ability to function either at the scene or later and could include "all physical custody (arrests), all vehicle and foot pursuits, all dispatched code responses (emergency), all motor vehicle accidents that require physical work and all calls which present an active threat to life and/or property" (Mitchell, 1983, p. 36).
- "*Critical incident*" was used to distinguish common exposures in the line of duty from exposures thought more likely to be problematic.
- Available research suggests that individual perceptions, rather than a specific subset of potentially *psychologically traumatic events*, may be key determinants of whether a potentially *psychologically traumatic* exposure becomes problematic.

For General Public

- Currently not a *diagnosis* in the DSM or ICD.
- Potentially *psychologically traumatic events* that may be commonly experienced by *public safety personnel*, but that may nonetheless evoke unusually strong emotional reactions.
- May occur when a person is overwhelmed by the scope, severity, personal connection, or extent of exposure to a given potentially *psychologically traumatic event*.
- Often mistakenly used interchangeably with *psychologically traumatic event* or *trauma*.

Diagnosis / Diagnostic

For Experts

- *Diagnosis* is the process of explaining a person's state of mental or physical *health* through examination and consideration of various types of evidence.
- *Diagnosis* is also a conclusion made about the nature of a *health* condition, illness, or disorder.
- *Diagnostic* criteria for making the *diagnosis* of a *mental disorder* include those listed in the *Diagnostic* and Statistical Manual of Mental Disorders (DSM) or the International Statistical Classification of Diseases and Related Health Problems (ICD).
- The word *diagnosis* refers broadly to any justifiable conclusion made by a regulated health professional within their scope of practice, not just the formulations presented in the DSM or ICD.
- A *diagnosis* of a *mental health condition* should not be made without considering the differential *diagnoses* of physical health conditions that could alternatively explain the person's state of *health*. Furthermore, physical health disorders also accompany *mental disorders*.

For General Public

- An explanation of a person's mental or physical *health* made by a qualified health professional within their scope of practice.
- The *Diagnostic* and Statistical Manual of Mental Disorders (DSM) or the International Statistical Classification of Diseases and Related Health Problems (ICD) provide *diagnostic* criteria for *mental disorders*.

First Responder(s)

For Experts

- The definition of "*first responder*" is continuing to evolve.
- A person with specialized training who is among the first to arrive and provide assistance at the scene of an emergency, such as an accident, natural disaster, or terrorist attack. Historically, *first responders* have traditionally included paramedics, emergency medical technicians, police officers, firefighters, and rescuers.
- Other trained members of organizations connected with this type of work, including public safety communications officials (e.g., 911 call centre personnel) and correctional officers, are also considered *first responders*.

For General Public

- The definition of "*first responder*" is continuing to evolve.
- A person with specialized training who is among the first to arrive and provide assistance at the scene of an emergency, such as an accident, natural disaster, or terrorist attack. Historically, *first responders* have included paramedics, police officers, special constables, firefighters, and rescuers.
- Other trained members of organizations connected with providing professional assistance at the scene of an emergency (e.g., public safety communications officials such as 911 personnel), may also considered *first responders*.

Health

For Experts

- The physical, mental, social, and some say spiritual, functioning of a person, which can range from poor to good (Huber, 2010; Huber, Knottnerus, Green, van der Horst, Jadad, Kromhout … & Smid, 2011; Thompson, MacLean, Roach, Banman, Mabior & Pedlar 2016; Thompson, Heber, VanTil, Simkus, Carrese, Sareen & Pedlar, 2019).
- *Health* can be described subjectively such as a person's own description of their *health*, psychological *well-being*, or health-related quality of life.
- *Health* also can be described objectively, such as observations by a family member or *health* professional.

For General Public

- Refers to how a person is physically, mentally, socially, and spiritually functioning.
- Can be described as how the person views their own *health* or as how others view a person's *health*.

Interpersonal Violence

For Experts

- One or more behaviours wherein an individual causes physical *trauma* or *psychological trauma* to another individual, including but not limited to, child maltreatment, intimate partner violence, elder abuse, assault by strangers, as well as violence related to property crimes, in workplaces, and other institutions.
- Potentially *traumatic events* that involve *interpersonal violence* may cause more severe or complex *mental health conditions* (including *mental disorders*) due to interpersonal betrayal and attachment disruption. Other potentially *psychologically traumatic stressors* or *events* (e.g., natural disasters, structure fires) can also lead to similar severity and complexity of *mental health conditions*. However, the personal and relational nature of *interpersonal violence* often leads to more complex *mental health conditions*.

For General Public

- Harmful physical and psychological behaviour towards another person.
- A type of potentially *psychologically traumatic event* or *stressor*.
- Can contribute to *mental health conditions* in either the person causing the harm or the person who was harmed.
- Examples of *interpersonal violence* include intimate partner violence, elder abuse, and workplace violence.

Mental Disorder

For Experts

- A clinically significant disturbance in an individual's cognition, emotion regulation, or behaviour that reflects dysfunction in the psychological, biological, or developmental processes underlying mental functioning where the person's condition meets DSM or ICD *diagnostic* criteria.
- Associated with significant di*Stress* in social, occupational, or other activities.
- Causes of *mental disorders* are thought to be multiple and interlinked, not linear, and related to various combinations of *traumatic events* or potentially *psychologically traumatic events,* genetics, biology, diet, socioeconomic factors, physical health conditions, physical environmental factors, and others.
- The symptoms and signs are not better explained by a physical health condition or the effects of a substance.
- Common, culturally consistent responses to a common *stressor* or loss, such as the death of a loved one, which do not meet accepted *diagnostic* criteria, are not *mental disorders*.
- Socially deviant behaviour (e.g., political, religious, or sexual) and conflicts that are primarily between the individual and society are not *mental disorders* unless the deviance or conflict results from a dysfunction in the individual which meets accepted *diagnostic* criteria.

For General Public

- A type of *mental health condition* that meets accepted criteria for *diagnosis* published in the DSM or ICD.
- Criteria for *diagnosis* include impaired functioning in social, workplace, or other activities.
- A *diagnosis* of a *mental disorder* might be made if the *diagnostic* criteria best explain a person's current condition.
- *Mental disorders* are thought to be caused by the interactions of different combinations of factors; for example, potentially *psychologically traumatic events* or *stressors,* genetics, biology, socioeconomic factors, physical health conditions, or physical environmental factors.
- A person could receive a *diagnosis* of more than one *mental disorder* at a time.
- Does not include normal responses to common *stressors* like the loss of a loved one, workplace pressures, living with a physical health condition, or chronic pain.
- *Mental disorder* is currently the preferred term instead of *mental illness*.

Mental Health

For Experts

- *"Mental"* refers to thoughts (thought content), feelings (emotions), and related brain functioning.
- *Mental health* varies on a continuum from "poor" to "good". Good *mental health* is a state of psychological *well-being*. Good *mental health* generally enables people to function, realize their abilities, cope with the normal *Stresses* of life, and contribute to their community.
- *Mental disorder* severity lies on a different continuum from *mental health* and varies from mild to severe (Keyes, 2010). A person can have good *mental health* even though they have a *mental illness* or a *mental disorder*. Conversely, but more commonly, a person can have poor *mental health* but still not meet the *diagnostic* criteria for any specific *mental disorder* as described in the DSM or the ICD.
- *Mental health* is influenced by a wide variety of determinants, not only potentially *psychologically traumatic events* and *stressors*.

For General Public

- Refers to a person's thoughts and feelings.
- *Mental health* exists on a continuum between poor and good. In good *mental health*, a person knows their abilities, copes well with normal *stress*, works well, and contributes to their community.
- People with a *diagnosis* of a *mental disorder* can be coping well and still have good *mental health*.
- On the other hand, a person can have poor *mental health* without having a *diagnosis* of a *mental disorder*.
- *Mental health* is influenced by a wide variety of factors, not only potentially *psychologically traumatic events* and *stressors*.

Mental Health Injury / Psychological Injury

For Experts

- Currently not a *diagnosis* in the DSM or ICD.
- Refers to any type of *mental disorder*, not only those that occur as a result of exposure to one or more potentially *psychologically traumatic events*.
- Injury means an acute state, not chronic states that can occur as a result of a physical or *psychological trauma;* however, colloquially injury can also mean a chronic state arising from an acute injury, for example, an *operational stress injury*.
- Commonly used to manage the stigma with associated language like *mental disorder*.
- *Mental disorders* or other *mental health conditions* often are caused by mechanisms other than exposure to a *psychologically traumatic stressor*. Examples include *mental disorders* such as major depressive disorder, anxiety disorders, personality disorders, schizophrenia, or other psychotic disorders.

For General Public

- *Mental health injury* and *psychological injury* are alternative ways of referring to *mental health conditions,* including *mental disorders,* especially when the *mental health conditions* or *mental disorders* are thought to be caused by exposure to potentially *psychologically traumatic events* and other *stressors*.
- *Mental health injury* and *psychological injury* are not *diagnostic* categories in the DSM or ICD manuals.
- The word *"injury"* has been used in efforts to destigmatize *mental disorders*, especially *posttraumatic stress disorder*.

Mental Health Condition/ Mental Health Challenge

For Experts

- Broad term that includes *mental disorders, mental illness*, and undiagnosed symptoms that could be explained by *mental disorder diagnoses*.
- Also includes states of poor *mental health* that do not meet DSM or ICD *diagnostic* criteria for *mental disorders*, including, for example, culturally consistent responses to common *stressors* and socially deviant behaviours where the person is functioning well.
- Some people prefer to use *mental health challenge* instead of *mental health condition* in an effort to reduce stigma.

For General Public

- Any state of poor *mental health*.
- Includes normal reactions to everyday *stressors*, as well as *mental disorders*.
- Some people prefer to use *mental health challenge* instead of *mental health condition* in an effort to reduce stigma.

Mental Illness

For Experts

- When used, refers to *mental disorders,* diagnosed or as yet undiagnosed.
- Ranges in severity from mild to severe.
- Associated with significant di*Stress* in social, occupational, or other activities.

For General Public

- When used, refers to *mental disorders*, diagnosed or as yet undiagnosed.
- Ranges in severity from mild to severe.
- Associated with significant di*Stress* in social, occupational, or other activities.

Moral Injury

For Experts

- Currently not a *diagnosis* in the DSM or ICD.
- Evolving concept that continues to be discussed among experts.
- One view is that *moral injury* is a type of *psychological trauma* characterized by intense guilt, shame, and spiritual crisis.
- Can result from experiencing a significant violation of deeply held moral beliefs, ethical standards, or spiritual beliefs, experiencing a significant betrayal, or witnessing trusted individuals committing atrocities.
- Has been described as an injury to one's identity (Nash, 2016), core being, spirit, and sense of self that results in fractured relationships (Brémault-Phillips et al. 2019).

For General Public

- Currently not a *diagnosis* in the DSM or ICD manuals.
- The concept of *moral injury* is still being debated by experts.
- Thought to be a type of *mental health condition* that results from a violation of deeply held beliefs and moral values.
- Has been described as an *injury* to one's identity, core being, spirit, and sense of self that results in fractured relationships.

Occupational Stress Injury / Organizational Stress Injury

For Experts

- Currently not *diagnosis* in the DSM or ICD.
- Evolving concepts that continue to be discussed among experts.
- One view is that occupational *Stress*ors sort into operational *Stress*ors and organizational *Stress*ors; however, the terms are emerging, and definitions remain unclear.
- To avoid confusion, the acronym "OSI" should be reserved for *operational stress injury*.

For General Public

- Currently not *diagnosis* in the DSM or ICD.
- One view is that occupational *Stress*ors can be classified into either operational or organizational *Stress*ors; however, the terms are emerging and definitions remain unclear.
- Often mistakenly used interchangeably with *operational stress injury;* therefore, wherever possible, use the acronym OSI only for *operational stress injury* and always be specific if referring to *occupational stress injury, organizational stress injury, or operational stress injury*.

Operational Stress Injury (OSI)

For Experts

- Currently not a *diagnosis* in the DSM or ICD manuals.
- Currently used primarily in Canada.
- Originally defined as any *mental disorder* or other *mental health condition* resulting from operational duties performed while serving in the Canadian Armed Forces.
- Used to describe a broad range of conditions including *mental disorders* such as anxiety disorders, depressive disorders, and *Posttraumatic Stress Disorder,* as well as *mental health conditions* that may not meet DSM or ICD criteria for *mental disorders* but still interfere with daily functioning in social, work or family activities.
- The term was coined by Canadian Lieutenant Colonel (Retired) Stéphane Grenier as part of a broad effort to decrease the stigma associated with other language (e.g., mental disorder, *mental health condition*) by categorizing *mental health conditions* as "*injuries*" that are as legitimate as physical injuries sustained during operational duties.
- Contemporary use refers to any *mental disorder* or other *mental health condition* resulting from operational *Stress*ors experienced while serving in a professional capacity, especially in military or other public safety professions.
- Generally, the operational *Stress*ors associated with an *operational stress injury* typically refer to potentially *psychologically traumatic events;* however, in some cases, operational *Stress* also refers to less severe elements of occupational duties (e.g., shift work, overtime, upholding a "higher image" in public).
- Occasionally, *operational stress injury* is mistakenly used synonymously with *organizational stress injury* or *occupational stress injury;* however, operational *Stress*, organizational *Stress*, and occupational *Stress* have all been defined differently in the current literature.
- Organizational *Stress*ors may include staff shortages, lack of training on new equipment, lack of appropriate resources, inconsistent leadership styles, and a perceived lack of support between co-workers and leaders.
- "Occupational *Stress*ors" has been used to refer broadly to both operational and organizational *Stress*ors.
- Currently, only *operational stress injury* has been defined and used with any regularity by members of the *mental health* community.

For General Public

- Currently not a *diagnosis* in the DSM or ICD manuals.
- Refers to any *mental disorder* or other *mental health condition* resulting from operational *Stress*ors experienced (any level of severity) while serving in a professional capacity, especially in military or other public safety professions.
- Often mistakenly used interchangeably with *occupational stress injury* or *organizational stress injury;* therefore, wherever possible, use the acronym OSI only for *operational stress injury* and always be specific if referring to *occupational stress injury, organizational stress injury,* or *operational stress injury*.

People with Lived Experience / Experts by Experience

For Experts

- People who are living with, have lived with, or are recovering from a *mental disorder* or *mental health condition*.
- May also include persons exposed to a potentially *psychologically traumatic stressor* or *event*.
- May also include the loved ones or other supporting persons who are engaged with people who are living with, have lived with, or are recovering from a *mental disorder* or *mental health condition* or exposed to potentially *psychologically traumatic stressor or event*.

For General Public

- People who are living with, have lived with, or recovering from a *mental disorder* or *mental health condition*.

Posttraumatic Growth (PTG)

For Experts

- Currently not a *diagnosis* in the DSM or ICD.
- Refers to positive personal changes that may result from an individual working to cope with the psychological consequences of exposure to *trauma* or a potentially *psychologically traumatic event*.
- Major dimensions of *posttraumatic growth* include: enhancement of relationships (e.g., increases in empathy, humility, and altruism); changes in self-perception (e.g., of personal resiliency, strength; increased acceptance of vulnerability and limitations); changes in life philosophy (e.g., re-evaluating what's important); and spiritual or existential change (Tedeschi, Park & Calhoun, 1998; Tedeschi, Calhoun, & Groleau, 2015).
- *Posttraumatic growth* is not merely bouncing back to pre-trauma levels of functioning, but positive growth beyond pre-trauma levels of functioning.
- *Posttraumatic growth* and *posttraumatic stress* can occur within the same person at the same time.

For General Public

- Currently not a *diagnosis* in the DSM or ICD manuals.
- Generally refers to the positive personal changes that may result from an individual's struggle to manage the consequences of being exposed to one or more potentially *psychologically traumatic events*.
- The positive personal changes may include such things as a new appreciation for life and future possibilities, a newfound sense of personal strength, improved relationships with others (e.g., a new focus on helping others), and spiritual or existential change.
- *Posttraumatic growth* is not merely bouncing back to pre-trauma levels of functioning, but positive growth beyond pre-trauma levels of functioning.

Posttraumatic Stress (PTS)

For Experts

- Currently not a *diagnosis* in the DSM or ICD.
- Has been used to refer to *stress* and/or *mental health conditions* arising from exposure to a potentially *psychologically traumatic stressor* or *event*.
- Has been used to refer specifically to *Posttraumatic Stress Disorder*, but has also been used to refer to *mental health conditions* with some features of *Posttraumatic Stress Disorder* that do not meet criteria for the *diagnosis* of *Posttraumatic Stress Disorder* but still interfere with daily functioning in social, work, or family activities.
- Can develop soon after exposure to a potentially *psychologically traumatic event* or progressively over time with cumulative exposures.
- Does not refer to reactions to *Stress*ful events or significant life changes that are not potentially *psychologically traumatic stressors/events,* so does not refer to normal reactions to common *stressors*.
- Often mistakenly used interchangeably with other terms such as *posttraumatic stress disorder;* therefore, wherever possible, using another more specific term will be more accurate and more helpful.

For General Public

- Currently not a *diagnosis* in the DSM or ICD.
- Has been used to refer to *stress* and/or *mental health conditions* from exposure to a potentially *psychologically traumatic stressor* or *event*.
- Has been used to refer specifically to *Posttraumatic Stress Disorder,* but has also been used to refer to *mental health conditions* that follow exposure to a potentially *psychologically traumatic event* and interfere with daily functioning in social, work, or family activities.
- Often mistakenly used interchangeably with several other terms; therefore, wherever possible, using another more specific term will be more accurate and more helpful.

Posttraumatic Stress Disorder (PTSD)

For Experts

- *Diagnostic* criteria are provided for *Posttraumatic Stress Disorder* in the DSM and ICD.
- A *mental disorder* which can occur following exposure to specific types of severe, potentially *psychologically traumatic events* perceived as involving severe threat to self or others.
- Symptoms can include:
  1. Intrusive involuntary memories, flashbacks, nightmares, or di*Stress* on exposure to triggers of the traumatizing event;
  2. Avoidance of reminders of the traumatizing event;
  3. Persistent, event-related negative moods and thoughts like fear, mistrust, shame, or detachment;
  4. Sleep disturbance, hypervigilance, startle response, irritability, or anger; and
  5. Sometimes significant dissociation, with amnesia or decreased responsiveness to external stimuli.
- The experiences last for more than one month and cause clinically significant di*Stress* or impairment in social, occupational, or other important areas of functioning.
- The symptoms and signs are not better explained by another mental or physical *health* condition or the effects of a substance.

For General Public

- *Diagnostic* criteria are provided for *Posttraumatic Stress Disorder* in the DSM and ICD.
- A *mental disorder* that can happen after exposure to psychological *stressors* during specific types of severe, potentially *psychologically traumatic events*.
- *Posttraumatic Stress Disorder* may involve different combinations of sleep disturbances, flashbacks, triggers, regular vivid recall, intrusive memories, avoiding reminders of the *psychologically traumatic event* and avoiding thinking about the *psychologically traumatic event,* trouble remembering parts of the *psychologically traumatic event,* persistently negative thoughts, low mood, anger, feeling emotionally numb and, having difficulties feeling emotionally connected to family or close friends.
- The experiences last for more than one month and cause significant di*Stress* and/or impairment in social, occupational, or other important areas of functioning.
- The *diagnosis* of *Posttraumatic Stress Disorder* is made if the peson's condition is not better explained by another physical or *mental disorder*.

Posttraumatic Stress Injury (PTSI)

For Experts

- Currently not a *diagnosis* in the DSM or ICD.
- Currently used primarily in Canada.
- Refers to a *mental health condition* that a person might acquire as a result of exposure to one or more potentially *psychologically traumatic events*.
- Used to describe a range of problems including, but not limited to, *mental disorders* such as *Posttraumatic Stress Disorder* and *mental health conditions* that may not meet DSM or ICD criteria for *Posttraumatic Stress Disorder* that still interfere with daily functioning in social, work or family activities.
- By categorizing *mental health conditions* as *"injuries"* that are as legitimate as physical injuries, the term can decrease the stigma associated with language such as *mental disorder* or *mental health condition.*

For General Public

- Currently not a *diagnosis* in the DSM or ICD.
- Currently used primarily in Canada to decrease the stigma associated with the word *"disorder"*.
- Currently, the term is most often used within the military and *public safety personnel* communities in Canada.
- Refers to a *mental health condition* that a person acquires as a result of exposure to one or more potentially *psychologically traumatic events*.
- Has been used by some people to refer to *Posttraumatic Stress Disorder,* but has also been used by some people to refer to several other *mental disorders*.

Posttraumatic Stress Syndrome (PTSS)

For Experts

- Currently not a *diagnosis* in the DSM or ICD.
- May be considered inaccurate or stigmatizing.
- Often mistakenly used interchangeably with several other terms; therefore, wherever possible, using another more specific term will be more accurate and more helpful.
- See also *posttraumatic stress injury, Posttraumatic Stress Disorder, posttraumatic stress*.

For General Public

- Currently not a *diagnosis* in the DSM or ICD.
- May be considered inaccurate or stigmatizing.
- Often mistakenly used interchangeably with several other terms; therefore, wherever possible, using another more specific term will be more accurate and more helpful.
- See also *posttraumatic stress injury, Posttraumatic Stress Disorder, posttraumatic stress*.

Psychological Trauma / Psychologically Traumatic Injury / Psychologically Traumatized

For Experts

- Currently not a *diagnosis* in the DSM or ICD.
- *Trauma* caused by exposure to *psychologically traumatic event* (Briere & Scott, 2015; Substance Abuse and Mental Health Services Administration, 2019).
- The manifestations of the *traumatic injury* may be consistent with one or more *mental disorders,* but may also be consistent with *mental health conditions* for which there are no *diagnostic* categories in the DSM or ICD.
- *Psychological trauma* is a unique, individual experience.

For General Public

- Currently not a *diagnosis* in the DSM or ICD.
- Any *mental disorder* or other *mental health condition* resulting from exposure to a *psychologically traumatic event*.
- *Psychological trauma* is a unique, individual experience that may not present the same way for every person.
- See also *mental disorder, mental health injury, posttraumatic stress injury, Posttraumatic Stress Disorder, Acute Stress Disorder*.

Psychologically Traumatic Event / Psychologically Traumatic Stress / Psychologically Traumatic Stressor

For Experts

- A *psychologically traumatic event* is a *stressful event* that may cause *psychological trauma*.
- Exposure to certain types of p*sychologically traumatic events* are included in the DSM and ICD criteria for the *diagnosis* of *Acute Stress Disorder* or *Posttraumatic Stress Disorder*.
- The terms are often preceded by the word "potentially" to underscore the importance of individual perception within a specific context when determining whether an event is a *psychologically traumatic stressor*.
- Examples include significant threats of harm to the self or loved ones, exposure to war as a combatant or civilian, threatened or actual physical assault, threatened or actual sexual violence, being kidnapped, being taken hostage, torture, natural or human-made disasters, or other mechanisms of severe physical injuries such as motor vehicle accidents and industrial accidents.
- Exposure to a potentially *psychologically traumatic stressor* can be direct (e.g., happened to me; witnessed it first hand) or indirect/vicarious/secondary (e.g., witnessed the aftermath; learned about the *trauma* happening to a loved one, or as part of providing support or care to another person, either professionally or personally).
- Not everyone exposed to a potentially *psychologically traumatic event* or *stressor* develops *psychological trauma*.
- Most *critical incidents* would be potentially *psychologically traumatic events,* but not all potentially *psychologically traumatic events* would be *critical incidents*.

For General Public

- Things that can cause *psychological trauma* like *Posttraumatic Stress Disorder* and other types of *mental health conditions*.
- The terms are often preceded by the word "potentially" to underscore the importance of individual perception within a specific context when determining whether an event is a *psychologically traumatic stressor*.
- There is often an element of significant threat to the physical safety of the self or others that may be associated with feelings of intense fear, horror, or helplessness.
- Examples may include some *adverse childhood events,* motor vehicle accidents, sexual and other types of violence, unexpected death or threat of death of loved ones, severe physical injury, military combat, natural disasters, or exposure to bodies or environmental hazards.
- Most *critical incidents* would be potentially *psychologically traumatic events,* but not all potentially *psychologically traumatic events* would be *critical incidents*.

Public Safety Personnel (PSP)

For Experts

- The definition of "*Public Safety Personnel*" is continuing to evolve.
- Currently used primarily in Canada.
- Broad term meant to encompass personnel who ensure the safety and security of Canadians.
- *PSP* include, but are not limited to, border services officers, public safety communications officials, correctional workers, firefighters (career and volunteer), Indigenous emergency managers, operational intelligence personnel, paramedics, police (municipal, provincial, federal), and search and rescue personnel.
- History:
  1. In the 2016 Standing Committee on Public Safety and National Security Report, "Healthy minds, safe communities", Public Safety Canada defined a "Public Safety Officer" as a broad term meant to encompass front-line personnel who ensure the safety and security of Canadians, including first responders / *tri-services* (i.e., firefighters, paramedics, police), search and rescue personnel, correctional services officers, border services officers, operational intelligence personnel, and Indigenous emergency managers.
  2. Feedback regarding the word "officer" in the term "Public Safety Officer" indicated many professional groups intended to be included felt excluded because they did not identify as officers; as such, the term *public safety personnel* has been adopted to reference persons acting in professional capacities to fulfil public functions with duties related to public safety.

For General Public

- The definition of *public safety personnel* is continuing to evolve.
- All *first responders* can also be referred to as *public safety personnel.*
- Broad term meant to include personnel who ensure the safety and security of Canadians.
- *PSP* include, but are not limited to, border services officers, public safety communications officials, correctional workers, firefighters (career and volunteer), Indigenous emergency managers, operational intelligence personnel, paramedics, police (municipal, provincial, federal), and search and rescue personnel.

Recovery

For Experts

- There is no universally agreed definition for this term, however, the concept is widely endorsed.
- Refers to the personally contextualized, self-determined journey to good *well-being* when a person has a *mental disorder*, a chronic physical *health* condition, or chronic pain.
- An ongoing process of change that increases the person's *well-being,* including symptom reduction but also living a meaningful life where the person has positive *mental health,* is hopeful and optimistic, and is participating and contributing (Mental Health Commission of Canada, 2017; College of Family Physicians of Canada, 2018).

For General Public

- The personalized journey to a way of living that allows a person with a physical or *mental health condition* to have positive *mental health* and good *well-being*.

Resilience

For Experts

- Generally used to describe the concept of adapting to or bouncing back from a negative event or experience.
- Defined in a number of different ways as something one has, something one develops, or something one uses, which reflects a lack of consensus over the specific qualities or components that make up *resilience*.
- Can refer to the *resilience* of individuals but can also refer to the *resilience* of groups (e.g., families, teams, organizations).
- *Resilience* has been used to describe the ability to adapt and maintain, or return to previous levels of good *well-being* in individuals or groups (e.g., families, teams, organizations).
- *Resilience* may be influenced by factors internal to individuals and by factors created by groups (e.g., families, teams, organizations).
- *Resilience* is not constant, but may vary over time due to internal and/or external factors.

For General Public

- A person's ability to adapt to challenges or bounce back after a bad experience.
- This ability can be further supported or undermined by the groups to which a person belongs (e.g., by their families, teams, organizations).

Stress / Stressor / Stressful Event

For Experts

- *Stress* describes the experience a person has while being impacted by one or more *stressors,* often characterized by psychological di*Stress* and physiological changes (e.g., increased heart rate, shallow breathing, muscle tension).
- *Stress* is a common experience and some *stress* can be a good thing if the *stress* leads to growth and adaptation; however, *stress* can result in *psychological trauma*.
- A *stressor* is a physical, radiological, biological, socioeconomic, or psychological force that acts upon a person during events such as a motor vehicle accident, loss of an important relationship, loss of employment, confronting an attacker, dealing with financial loss, or adverse childhood experiences.
- A psychologically *stress*ful *event* is an episode in time during which a *stressor* operates on a person and causes an emotional experience accompanied by predictable biochemical, physiological, and behavioural changes.
- Confusingly, the word *stress* is often used synonymously, sometimes mistakenly, when people are referring to *traumatic stress, psychological trauma,* a *mental health condition,* or a *mental disorder* associated with experiencing a *stressful event*.
- *Stress, stressor,* and *stressful event* are often used interchangeably to refer to a potentially *psychologically traumatic event* or an *adverse childhood experience*.

For General Public

- *Stress* means the way a person feels or looks when they are affected by a *stressor*.
- *Stress* is a common experience and some *stress* can be a good thing if the *stress* leads to growth and adaptation; however, *stress* can result in *psychological trauma*.
- A *stressor* is something that puts pressure on a person physically or mentally.
- A person experiencing a *stressful event* is being impacted by one or more *stressors* that are causing them to experience *stress*. If the experience is severe enough, *stress* may result in a *psychological trauma* that can lead to a *mental health condition,* such as *Posttraumatic Stress Disorder*.
- Confusingly, the word *stress* often is used interchangeably, sometimes mistakenly, when people are referring to *traumatic stress, psychological trauma,* a *mental health condition,* or a *mental disorder* associated with experiencing a *stressful event*.
- *Stress, stressor,* and *stressful event,* are often used interchangeably to refer to a potentially *psychologically traumatic event* or an *adverse childhood experience*.

Trauma / Traumatic Injury

For Experts

- Currently not a *diagnosis* in the DSM or ICD.
- *Trauma* can be (a) physical, meaning an injury to living tissue caused by an extrinsic physical, biological, or radiological agent, or (b) psychological, meaning a disordered psychic or behavioural state resulting from severe mental or emotional *stress*.
- In the *mental health* context, *trauma* is a person's experience during an event so di*Stress*sing to them that it overwhelms them emotionally. Severe psychological *trauma* is viewed as the etiology (cause) of *Posttraumatic Stress Disorder*.
- A person can experience physical *trauma* without also experiencing *psychological trauma,* as in minor physical *trauma* that causes a minor laceration, sprain, skin infection, or sunburn. On the other hand, severe physical *trauma* that causes unstable multi-organ system polytrauma usually is associated with psychological *trauma*. It has been hypothesized that physical *trauma* to the central nervous system, such as penetrating or blunt force traumatic brain injury, can also contribute causally to psychiatric sequelae like *Posttraumatic Stress Disorder*.
- Psychologically *Stress*ful experiences are not necessarily *traumatic*. People can feel *Stress*ed without experiencing *trauma*.
- *Injury* means an acute state, not chronic states that can occur as a result of a physical or *psychological trauma*. However, colloquially injury often is used to describe a chronic state arising from an acute injury, for example, an *operational stress injury*.

For General Public

- Currently not a *diagnosis* in the DSM or ICD.
- *"Trauma"* is something that causes physical, emotional, spiritual, or psychological harm. In the *mental health* context, *trauma* is a person's own experience during an event so di*Stress*sing to them that it overwhelms them emotionally.
- In the *mental health* context, *psychological trauma* is viewed as the cause of a *mental disorder* like *Posttraumatic Stress Disorder*.
- Psychologically *Stress*ful experiences are not necessarily traumatic. People can be feel *Stress*ed without experiencing *trauma*.

Traumatic Event / Traumatic Stress / Traumatic Stressor

For Experts

- Currently not a *diagnosis* in the DSM or ICD.
- In the context of *mental health* discussions, usually refers to a potentially *psychologically traumatic event*.
- The DSM and ICD specify the types of potentially *psychologically traumatic events* that serve as criteria for a *diagnosis* of *Posttraumatic Stress Disorder*. (For details, see *Psychologically Traumatic Event*).
- For clarity, the word "psychological" or "physical" should be used, as in "physically *traumatic event*" or "potentially *psychologically traumatic event,*" since not all potentially *psychologically traumatic events* cause physical trauma, and physically traumatic events are not necessarily psychologically traumatic.

For General Public

- Currently not a *diagnosis* in the DSM or ICD.
- In the context of *mental health* discussions, usually refers to a potentially *psychologically traumatic event*.
- Using these terms without specifying "psychologically" or "physically" can cause confusion about the nature of the potentially *traumatic stress* or *event*.

Tri-Services

For Experts

- A subset of *public safety personnel*.
- Refers specifically to firefighters, paramedics, and police.

For General Public

- *Public safety personnel* who are firefighters, paramedics, and police.

Vicarious Traumatic Stress

For Experts

- Currently not a *diagnosis* in the DSM or ICD.
- *Stress* that can occur following indirect exposure to a potentially *psychologically traumatic event* being exposed to a traumatized person (e.g., witnessed the aftermath; learned about the *trauma* happening to a loved one; or as part of providing support or care to another person, either professionally or personally).

For General Public

- Currently not a *diagnosis* in the DSM or ICD.
- *Stress* that a person feels when they learn about *trauma* experienced by another person.

Vicarious Traumatization

For Experts

- Currently not a *diagnosis* in the DSM or ICD.
- *Psychological trauma* that occurs following indirect exposure to a potentially *psychologically traumatic event* or being exposed to a traumatized person (e.g., witnessed the aftermath; learned about the *trauma* happening to a loved one; or as part of providing support or care to another person, either professionally or personally).
- It can be "the transformation that occurs within the therapist as a result of empathic engagement with client's *trauma* experiences and their sequelae" (Pearlman & Mac Ian, 1995).
- Has been conceptualized as being exacerbated by, and perhaps even rooted in, the open engagement of empathy, or the connection with the client that is inherent in counselling relationships (Pearlman & Saakvitne, 1995b; Trippany, Kress, & Wilcoxon, 2004).
- Reflects exposure of counsellors to client's traumatic material and encompasses the subsequent cognitive disruptions experienced by counsellors (Figlet, 1995; McCann & Pearlman, 1990; Trippany, Kress, & Wilcoxon, 2004).

For General Public

- Currently not a *diagnosis* in the DSM or ICD.
- *Psychological trauma* that can occur in people who are indirectly exposed to a potentially *psychologically traumatic event* (e.g., witnessed the aftermath; learned about the *trauma* happening to a loved one; or as part of providing support or care to a traumatized person, either professionally or personally).

Well-being (Wellbeing)

For Experts

- There are many ways of understanding the term *"well-being,"* and there is no universal standard for spelling *well-being* with a hyphen or *wellbeing* without a hyphen.
- Psychologists often talk about forms of subjective psychological *well-being,* like happiness or quality of life. Economists talk about forms of objective *well-being,* like gross national product or household income. Recently, researchers worldwide have begun to think of *well-being* in broader terms that encompass all the different types of *well-being*.
- Veterans Affairs Canada (VAC) and the Canadian Armed Forces (CAF) describe *well-being* using a broad framework that includes seven interacting domains:
  1. employment/purposeful activity;
  2. finances;
  3. *health*/disability;
  4. life skills/preparedness;
  5. social integration;
  6. housing/physical environment, and;
  7. cultural/social environment. The cultural/social environment includes a diverse range of factors like values, norms, and healthcare and other social security systems. Elements of each domain in this framework can vary from poor to good based on subjective and objective measurements (Thompson, MacLean, Roach, Banman, Mabior & Pedlar 2016; Thompson, Heber, VanTil, Simkus, Carrese, Sareen & Pedlar, 2019).
- In the VAC-CAF type of *well-being* framework, *health* is one domain of *well-being* that can interact with the other domains to impact *well-being;* for example, having a good job supports good *mental health,* but it is equally true that having good *mental health* supports finding and keeping a good job.
- The subjective and objective variability from poor to good in each domain underscores the complexity of *well-being* and the importance of understanding *health* as part of a system with bidirectional causality, rather than something that operates in isolation.

For General Public

- There are many ways of understanding the term *"well-being."*
- Examples include psychological *well-being* like happiness or quality of life, or economic *well-being* like household income or gross national product.
- Veterans Affairs Canada (VAC) and the Canadian Armed Forces (CAF) describe *well-being* using a broad framework that includes all ways of thinking about *well-being* across seven interacting domains:
  1. employment/purposeful activity;
  2. finances;
  3. *health* and abilities;
  4. life skills/preparedness;
  5. social integration;
  6. housing/physical environment, and;
  7. cultural/social environment, which includes things like norms, values, healthcare, and other support services.

Wellness

For Experts

- Many people and agencies have different understandings of the word "*wellness*."
- The First Nations Mental Wellness Continuum Framework (FNMWCF) defines mental *wellness* as a balance of the mental, physical, spiritual, and emotional (Health Canada and Assembly of First Nations, 2014). This balance is enriched when individuals have: Purpose in their daily lives whether it is through education, employment, caregiving activities, or cultural ways of being and doing; Hope for their future and for those of their families that is grounded in a sense of identity, unique Indigenous values, and having a belief in spirit; a sense of Belonging and connectedness within their families, to community, and to culture; and finally, a sense of Meaning and an understanding of how their lives and those of their families and communities are part of creation and a rich history.
- There has been much overlap between the words "*wellness*," "*health*," and "*well-being*," including using the words interchangeably.
- The Veterans Affairs Canada *well-being* framework enables separation of words this way:
  1. *Well-being*: defined as in the VAC composite, superordinate type of framework.
  2. *Health*: a domain of *well-being*, influenced by and influencing *well-being* in the other domains.
  3. *Wellness*: ways of living to achieve good *well-being*, particularly in the *health* domain.

For General Public

- Many people and agencies have different understandings of the word *"wellness."* It is unlikely that a consensus definition is possible at this time.
- The First Nations Mental Wellness Continuum Framework (FNMWCF) defines mental *wellness* as a balance of the mind, body, soul, and emotions. In this framework, mental *wellness* is enriched when a person has purpose, hope for their future, a sense of belonging, and a sense of meaning.

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The field of mental health is ever-changing; the Glossary is a "*living document*" that will be revised over time to reflect new understandings.

CIPSRT
Canadian Institute for Public Safety Research and Treatment

ICRTSP
Institut canadien de recherche et de traitement en sécurité publique

APPENDIX E

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