

Report of the Expert Panel  
on Police Officer Deaths by Suicide

September 2019

## Foreword: Respecting Our Nine Lost Officers and Their Survivors

We begin by extending our respect and our appreciation to the families, friends and colleagues of the nine police members whose untimely deaths by suicide during one single year became the catalyst for our Review Panel. We know it cannot have been easy for these survivors to share their grief alongside their generous and thoughtful observations on a system that was at times supportive, and too often flawed and frustrating.

We want these survivors to know that we recognize their loved ones for the fullness of their lives. Each of these nine individuals served the public. Each of them committed themselves to high standards of professionalism. Each of them chose and trained for a career filled with danger, stress, trauma and fatigue in order to keep our communities safer for all. And, each of them also lived, laughed and enjoyed the loving company of their families, friends, neighbours and colleagues.

We decided early as a panel that we would not identify the nine by name, nor would we showcase any details of their life and passing. Policing is much too small a community to do so without violating privacy. But moreover, we chose to direct this report toward the future. We chose to honour the nine by learning all that we can from their experience, and our results are presented as collective findings gathered from the individual as well as shared journeys of these fallen officers. And, we hope that by joining with them in this manner, we might help to craft a legacy of better outcomes for all their brothers and sisters, present and future, who work within the policing system in Ontario, and beyond.

The charge given to us by the Chief Coroner was clear in this regard: *“Nine officers died by suicide. What would they and their survivors say should have been done differently?”*

Throughout our deliberations and through this report, we offer our best attempts to answer that question on their behalf.

*Respectfully,*

*The Members of the Ontario Chief Coroner’s Expert Panel on Police Officer Deaths by Suicide  
September 2019*

## Executive Summary

During 2018, nine deaths by suicide occurred among serving and retired police officers in the province of Ontario. This number was thought to be unprecedented\*. Soon after the year ended, the Office of the Chief Coroner initiated an expert panel review process. The eight-member panel began its work in June 2019. The experts on the panel understood that world research on suicide prevention has demonstrated that any specific death by suicide is difficult to predict or prevent, given that the known risk indicators for suicide also exist in large numbers of people who never attempt or die by suicide. Despite this, however, there are a number of evidence-based risk indicators for suicide, which when taken together, provide a list of factors known to be present in the majority of cases of completed suicide. Therefore, these points of risk can be used as potential targets for intervention when dealing with a vulnerable individual, and for the panel's purpose, these points of risk could serve as a method for organizing and understanding the information obtained on the nine deceased police officers. These risk indicators and potential targets for intervention to prevent suicide are described in Part One of our report.

These risk patterns were clearly evident in all nine of our subject officers' lives. In Part Two, we identify several characteristics unique to policing that may place all police members at greater risk, including the presence of mental health challenges, whether mild, moderate or severe. Given the presence of a diagnosable mental disorder (often Depression) in over 90% of those who die by suicide, the panel interpreted its mandate to extend beyond preventing deaths by suicide, to include a focus on improving mental health outcomes for all police members.

In Part Three of our report, we introduce and discuss seven pathways to better outcomes. The first of these, and perhaps the most vital, is the normalization of mental health issues. We call for deliberate steps to introduce a more open culture that will support earlier and continuing visibility of mental health conditions, better and sustained access to care, treatment and recovery, and an end to the isolating social disconnections that can often carry these conditions to their extremes. In a cross cutting manner, the six remaining themes build upon other aspects of this culture to strengthen organizational and clinical supports, to protect the strong sense of identity that police members value deeply, to more actively inform and engage police members' families and outside supports, and to better unify and align the tremendous efforts at improvement that are already underway across the policing and mental health systems. Alongside this discussion, we also feature in a running sidebar a number of specific observations on the strengths and weaknesses in the current police and mental health ecosystem. In Part Four, these themes are consolidated into a broader legacy.

---

### \* A Note About the Number

There is currently no requirement in Ontario for Coroners or others to record or track deaths by suicide among first responders, including police. Therefore, it is not known if this number of suicides in a single year was higher than the number in previous years.

Statistically, it is much higher than reported rates in the general public. Anecdotally, it may reflect increases in mental health issues across the policing sector.

For the panel, for police services and police association officials, for health professionals, and most notably for the surviving families, it is an alarming and unacceptable number.

---

Assembled under 14 main recommendations in Part Five of this report, our panel outlines a total of 36 actions and specifications, most of which include proposed roles and responsibilities, and all of which reflect a continuing theme of collaboration. First among these is a call for the formation of an Ontario Police Members Mental Health Collaborative (OPMMHC) to serve as a standing body that will initiate, guide, monitor and report on an urgent and comprehensive plan of action in Ontario.

The panel members are named in the Appendix, and we are all grateful to Dr. Dirk Huyer for his leadership in assembling this expert panel and for inviting us to serve in this important work. We also extend our thanks to the staff in the Office of the Chief Coroner for their valued guidance throughout our process.

## TABLE OF CONTENTS

<b>i</b>	Foreword: Respecting Our Nine Lost Officers and Their Families
<b>ii</b>	Executive Summary
<b>1</b>	Part One: Understanding the Common Tragedy in Any Death by Suicide
<b>4</b>	Part Two: Learning From Deaths by Suicide and Mental Health Issues in the Context of Policing
<b>6</b>	Stigma and Self-stigma for Mental Health Issues
<b>6</b>	The Lifeline of Police Identity
<b>8</b>	The High Costs of Accommodation
<b>8</b>	The Give and Take of Post-Traumatic Stress Disorder (PTSD) Presumptive Policy in Ontario
<b>9</b>	The Confounding Interplay among Workplace Stressors and Life Events for Police
<b>10</b>	An Enduring Commitment to Duty Despite the Personal Costs
<b>11</b>	Part Three: Seven Pathways to Better Outcomes
<b>11</b>	1. Normalizing Mental Health Challenges
<b>12</b>	2. Navigating Through Transitions
<b>13</b>	3. Continuing Access to Quality Care and Solutions
<b>14</b>	4. Resourcing, Accommodation and Burnout
<b>15</b>	5. Preserving Identity: The Criticality of Criminal or Police Act Charges and Social Media
<b>15</b>	6. Managing Suicide Events
<b>17</b>	7. Joint Ownership and Collaborative Action
<b>18</b>	Part Four: A Much Broader Legacy
<b>19</b>	Part Five: Our Recommendations for Action
<b>22</b>	Appendix: Members of the Chief Coroner’s Expert Panel

## Part One: Understanding the Common Tragedy in Any Death by Suicide

Our panel consisted of eight members selected by the Chief Coroner of Ontario for the expertise and perspective that each member could bring to the review. Several members are mental health professionals with expertise in suicide and suicide prevention, with experience working with police and other first responders. Others are current or past members of police organizations representing executive ranks, civilian specialties, and front line police officers with lived experience. One member is a mental health professional with extensive experience working with a police service outside of Canada, which has a reputation for excellence in promoting member mental health and well-being. One member is an educator and researcher with a special interest in policing culture. An early priority for the panel was to share their expertise and find a common frame of reference for understanding suicide. Following a discussion of the literature and the task at hand, two well-researched models for understanding suicide appeared to best fit the requirements for the review, the Canadian Forces Modified Mann Model for Suicide Prevention, and the Policing and Mental Health Ecosystem, and both are discussed further below. The panel also received input from outside delegations. We accessed a wide range of literature on the subject, digested other models from medical and sociological research, and we consulted the notes and themes culled from often painful interviews with survivors.

We learned that there is no prototype. Each and every suicide, whether attempted or completed, is in many ways as unique as the person involved. Although there is no single pattern that all suicides follow, the panel reviewed commonly studied and accepted factors associated with death by suicide. These include the presence of a **mental health problem**, often **depression**, combined with: a **stressful life event** or **significant loss**, which may be personal (loss of an important relationship through separation or divorce); experiencing **stressful or overwhelming events related to work**, such as violence or loss of status; or **stress due to other factors** (especially those causing embarrassment or shame). These conditions and events may then lead vulnerable persons to start thinking of suicide as a “way out”, or a way to solve their problems. There are then a number of factors, which have been shown to increase a person’s chances of acting on these thoughts and dying by suicide. These factors include: **impulsivity**, where either the person acts quickly and without much consideration, when a method of suicide is close at hand; or, the person uses drugs or alcohol which can decrease impulse control and lead to impulsive action; **hopelessness or pessimism**, where the person no longer believes there can be positive solutions or outcomes for them; **emotional dysregulation**, where the person is having difficulty controlling or moderating their feelings and behavior, and may be angry, aggressive, or prone to risk-taking; **access to lethal means**, where the person has a lethal method of death close at hand, which gives them no chance to deliberate on their actions, and kills quickly; and, **contagion or imitation**, where a vulnerable person learns of the death by suicide of someone whom they admire, or with whom they identify, and suicide begins to look like a “reasonable alternative” to the stresses and problems the vulnerable person is facing (the phenomenon of “copycat suicides” when the suicide of a public figure or celebrity is widely publicized is an example of this).

While hope and opportunities for intervention will always remain, once a clear intention to end one's life has been formed, options narrow considerably for preventing that death. There are many more opportunities before that point to prevent that decision from being made.

We recognized a distinctive pattern that would prove vital to our deliberations, a pattern that was also clearly evident in our nine subject deaths. We observed that by the time each of our subjects formed that determined intention to end his or her life, each had traveled a series of pathways, and each pathway had reached its end. The intersection of three specific pathways stood out for us. One is the path of acute mental health issues, often with associated substance use disorders. Another is the path of lost or diminished access to timely and quality care, effective treatment services and a range of essential supports. And the final one is the path of actual or perceived emotional disconnection from family, friends, and organization, often pushed to its endpoint by one or more precipitating events, sometimes at work, and more often in personal and family life.

We recognize that this observation may not break new ground in medical science, but our own discussions of this evident pattern proved instrumental in shaping the direction of our review. We recognized that we would be greatly limited if we were to direct our efforts solely to 'preventing suicides', per se. On the other hand, the imagery offered by these three critical pathways and their ultimate tragic convergence opens a much wider field of opportunity for changing the conditions. We know that if these conditions are unchanged, they will continue to lead some to that ultimate point of despair, and they will most certainly lead too many others to experience deterioration in the quality of their life and career. It is on these upstream aims and opportunities for improvement that we have chosen to focus this report.

We reviewed available literature and best practices in suicide prevention with a view to anchoring our own work in credible models. We noted that the US Air Force implemented a comprehensive suicide prevention program to reduce the risk of suicide, implementing 11 initiatives aimed at strengthening social support, promoting development of social skills, and changing culture to encourage effective help-seeking<sup>1</sup>. We also found utility in the Mann Model for Suicide Prevention in the Community<sup>2</sup>. Moreover, we found a closer fit with the adaptations to that model made by the Canadian Forces (CF).

In many ways, the CF-modified Mann model<sup>3</sup> (Figure 1) reflects a wider range of opportunities for intervention that are consistent with our pathways observations, and which also closely align with the paramilitary nature of policing and its organizational culture.

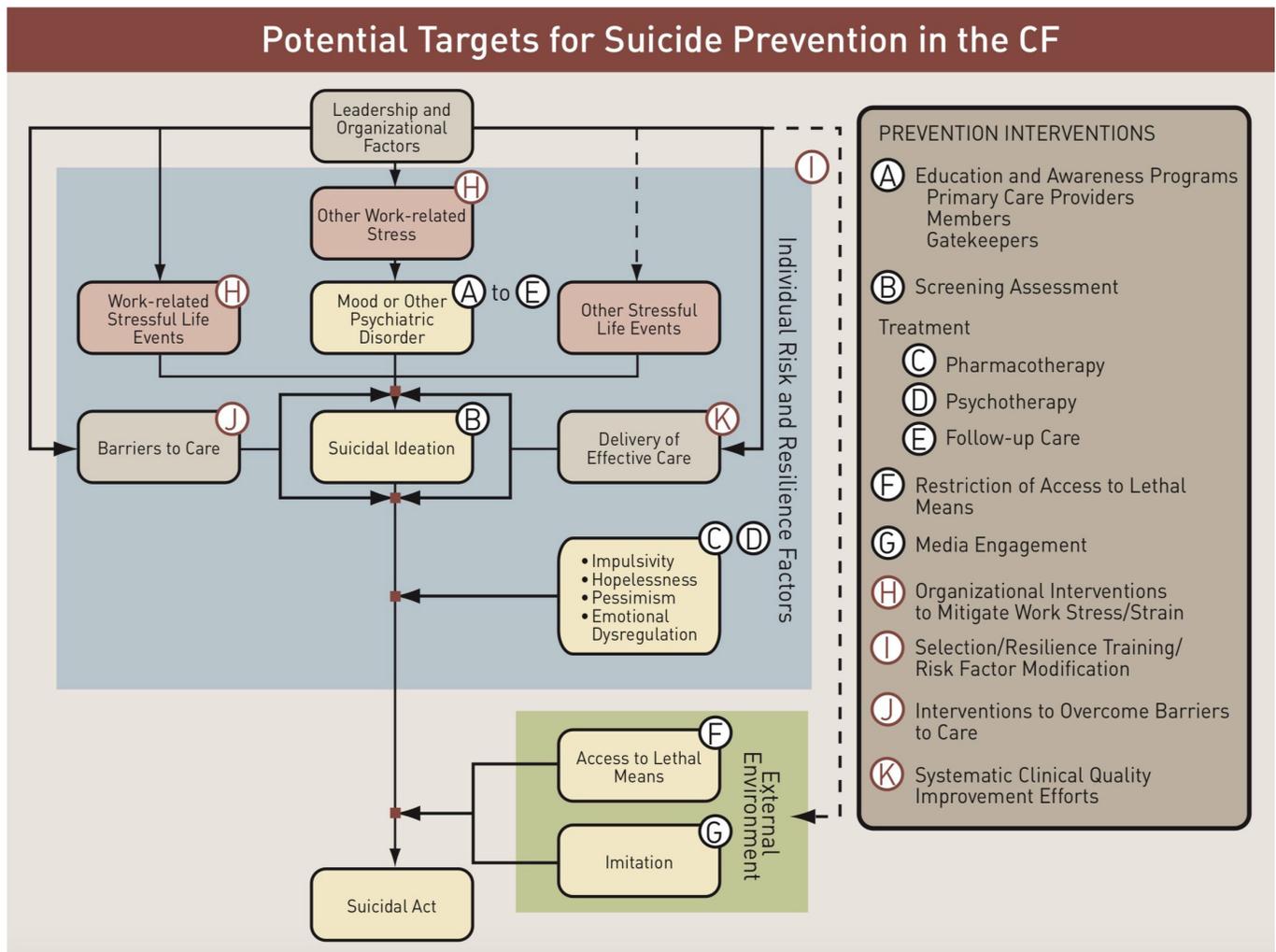
---

<sup>1</sup> USAF (2001). [The Air Force Suicide Prevention Program: A description of program initiatives and outcomes \(AFPAM 44-160\)](#). Suicide Prevention Resource Center.

<sup>2</sup> Mann JJ, Apter A, Bertolote J, Beautrais A, Currier D, Haas A et al. Suicide prevention strategies: a systematic review. JAMA 2005 October 26;294(16):2064-74.

<sup>3</sup> [Report of the Canadian Forces Expert Panel on Suicide Prevention \(PDF\)](#).

**Figure 1: Canadian Forces Modified Mann Model for Suicide Prevention**



We include in our recommendations (see Part Five below) a call for further research and development that might lead to a police-specific version of the CF-modified Mann model for broad application across the sector, incorporating any additional factors and interconnections addressed within this report.

## Part Two: Learning from Deaths by Suicide and Mental Health Issues in the Context of Policing

Our mandate was to examine deaths by suicide specifically among police officers. No doubt, much of the general knowledge and social science about suicide applies as much to this sub-set as it does to the general population. Police members are people first, and like everyone else, their lives are subject to the same successes, challenges and complexities as their non-policing peers. But, even the expression of our mandate implies that there might be something different from the norm in the pathways traveled by our nine, and by other police officers and civilian members that have arrived at the same tragic point outside the scope of our study. Our panel shared that same suspicion from the outset, and we set out to dive deeply into the question.

First, we noted that there is important work being done across Canada to better understand, through research, the mental health and well-being challenges faced by those in the policing profession, as well as in the broader community of first responders. Specific priority has been placed by the federal government on understanding and serving the mental health needs of public safety personnel in Canada through a number of efforts, including the passing of the Federal Framework on PTSD Act in 2018. The Canadian Forces has invested considerable research and development to better serve the mental health needs of active service members and veterans. Our panel recognizes the work of the Canadian Institute for Public Safety Research and Treatment (CIPSRT), the Canadian Institute for Military and Veteran Health Research (CIMVHR), their funding partners, and countless others working in this field for the commitment they have shown to improving outcomes for first responders, including police. The deliberations, conclusions and recommendations of our own panel are timely and relevant in the overall pattern of efforts in Canada in this regard.

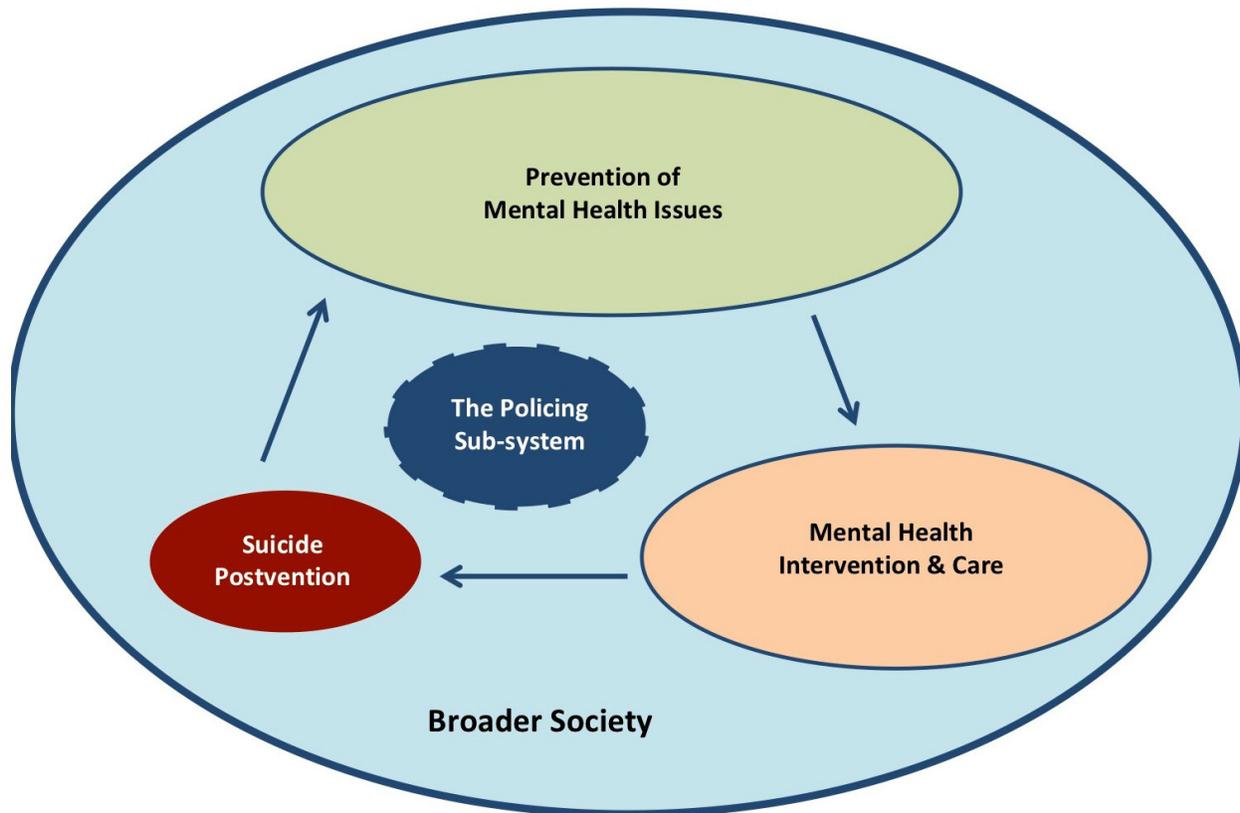
We also note that there have been significant advances in mental health awareness and resilience training across Ontario police services in recent years, along with a growing number of staff and consulting psychologists embedded within the ranks to increase access to professional support and organizational guidance. In 2017, the Canadian Association of Chiefs of Police (CACCP) established a Psychologist Sub-Committee under its Human Resources and Learning standing committee in an effort to achieve greater alignment and to create a network of best practices, among other aims.

The Ontario Provincial Police (OPP) has been engaged in a multi-pronged examination of mental health and suicides among its members, and the efficacy of current mental health supports available through its partnerships with its principal collective bargaining units, the Ontario Provincial Police Association (OPPA) and the OPP Commissioned Officers Association (COA). They have also engaged within these studies the active support of charitable and not-for-profit agencies that provide peer support, early intervention, and health care referrals, most of them working on a volunteer basis. The OPP reviews are broader in scope than our review, spanning a longer time frame of lived experience and including extensive consultations with active and retired members. We were fortunate to have the opportunity to interact with their study team members, their executives, and the OPPA during our own deliberations, and to review some of their findings and several proposed and promising solutions that are well underway.

We also received delegations from the Toronto Police Association (TPA), the Police Association of Ontario (PAO), and the Ontario Association of Chiefs of Police (OACP), each of whom showcased progressive and encouraging steps being taken along with expanded services in place or under development. We gained an international perspective on emerging practices related to police well-being from a recent global scan executed and summarized for us by a team from Deloitte.

All of these discussions yielded a progressively clearer picture of a policing and mental health ecosystem (see Figure 2), as others have noted in their own research. In our view, mental health and wellness issues in general, responses to moderate to acute illness, and deaths by suicide must be situated and understood in this context if we are to change the conditions and reduce risk for all police officers and civilian staff.

**Figure 2: A Policing and Mental Health Ecosystem**



We note there is an extensive health and social infrastructure intended to serve the broader public across Ontario in every phase of prevention, as illustrated in Figure 2. And, we also learned of ongoing initiatives to strengthen those supports, reduce suicide risk, and improve mental health outcomes for everyone, including police members. We encourage interested readers to consider all of these ongoing efforts to improve outcomes. Within the scope of our own report, suffice to say that the evident levels of commitment to these issues within policing give strong evidence that there are indeed apparent and urgent differences from broader society in the pathways experienced by police officers and their civilian colleagues in the policing sector.

Through our own analysis and discussions, we developed several observations on factors that are either unique, or at least uniquely acute within policing culture. We outline below those we found most salient to our study, and we highlight them for their real and potential impacts upon the mental wellness of police service members in Ontario.

## Stigma and Self-stigma for Mental Health Issues

We often hear of stigma as a major factor in how society responds to persons experiencing mental health issues, and we salute efforts such as the Bell Let's Talk initiative, anti-stigma outreach programs from the Canadian Mental Health Association (CMHA), the Centre for Addiction and Mental Health (CAMH), and a host of community based organizations and public and private sector agencies. No one is served well by a social prejudice that differentiates mental suffering from physical, and we believe outcomes would be considerably better for everyone if this false separation could be eliminated.

And so, the starting point for the average police member may be no different than for others. At least, that is, until they enter the academy, hit the streets, or begin to work at the communications centre. In most police jurisdictions across Ontario, estimates run as high as 40% of police calls for service being tied to incidents involving persons with mental health issues. Whether or not the police are the appropriate response in many of these cases is a topic of considerable debate and outside the scope of our study. But, the fact remains that within the first few years of service, a police officer, communicator, or other specialist will have come to recognize those with mental health issues among the highest frequency of calls, and often for patrol officers they may even rank among their primary encounters with the public. Sadly, if the police are being called, they may also be encountering such individuals at the very worst times and often under the most critical stages of their condition. And in extreme cases, these encounters may involve violence and a direct threat to the safety of the public and that of the responding officers. It is also worth noting that it is police officers that must respond to almost every suicide that occurs in the general public.

Police members have reported to us directly and in other studies we consulted that notwithstanding their high degrees of compassion, training and their on-scene professionalism that is the norm in these thousands of calls for service, most police members will soon come to regard any person with mental health issues as someone they would never want to be. They also told us that they often become disillusioned about the effectiveness of mental health care when they bring acutely mentally unwell people to hospital only to see them leave shortly afterwards with little to no change in their condition or circumstances.

## The Lifeline of Police Identity

Sworn police officers in Ontario and across Canada are invested with extraordinary responsibilities. They have the power under due circumstances to deny a person's freedom through arrest and detention, to enter private homes and communication devices with judicial authorization, to investigate and interrogate, to confiscate vehicles and other property, and when required, to apply escalating levels of force up to and including ending someone's life. They carry a range of use-of-force options on their duty belt and in their patrol car, and while they have an unenviable obligation to use them when warranted, they also carry the most exacting levels of accountability to formal authorities, to public oversight bodies, and to the informal world of mainstream and social media. When crisis or violence erupts, members of the public tend to move away from it, while police officers are duty-bound to move toward it. They must face it head on, often with great risk to themselves and their on-scene colleagues on whom they often must rely so that they remain safe and, so that no one else is injured.

Police officers represent 0.18% of the Canadian public (a number that is similar in Ontario). Put another way, 99.82% of Canadians do not carry these same authorities and responsibilities. Most police members will tell you that their career is not a job but a calling, and this distinction from almost all other Canadians is not lost on them. It is a source of great pride, and it carries its own burdens and every day stressors that most of us cannot imagine.

In any occupation, if a co-worker began to report or display mild symptoms of a mental illness, such as depression, anxiety disorder, or even moderate substance use, his or her colleagues might be alarmed, might recognize and pick up some workload imbalance, and might even be troubled periodically by behaviour they see as odd. It is doubtful that most co-workers would feel threatened by this individual's personal condition except in rare and extreme circumstances.

In policing, if a member reports or displays mild mental health issues, for at least some colleagues and even for the member himself or herself, such 'odd behaviour' can rise to life and death significance. It could be interpreted as, or merely feared to become a direct threat to the member and any colleagues who may be called to rely upon him or her at any time during a shift. While such dire situations may be infrequent in reality, they are by their nature unpredictable, and there is little margin for error when they occur. Apparently, from members' own disclosures, this is not lost on the average police officer, ever.

When combined with the self-stigma described above, this fear of being the one to let down the team may be even greater for the officer with the mental health issue, no matter how mild or moderate, than it is for his or her colleagues. Officers are trained to be team players and in truth, they will typically support one another. But, this may not be what goes through the mind of the afflicted. Instead, due to the early training and conditioning and the ongoing workplace culture of policing, many officers report becoming quite binary in their view of such things: either you are fit for duty, or you are not. As such, any loss or limit on your ability to perform the full scope of your duties can amount, in the mind of the individual, to a loss of your identity as a police officer.

Interestingly, this is not usually the same, or at least is not experienced to the same degree, if the deficiency arises from a physical injury or illness. Injuries are not uncommon in police work or even in off-duty activities. Illnesses can affect everyone in relatively uniform measure. Police can be very supportive, and when illnesses or injuries are severe, they often exhibit outstanding levels of support for their ill or injured colleagues.

But, likely due to the stigma and self-stigma they share, when the deficiency is due to psychological injury or arises from the same forms of mental health issues that affect 20% of all Canadians, the harsh and unfortunate term that is often invoked in policing is "broken toys". In other words, you are no longer fit for duty. And, as we all recall from childhood, once broken, most toys cannot be fixed.

Faced with this harsh and often binary reality, a great number of police members will deny and shield the presence of mental health issues for as long as they can. The literature suggests that they may turn, in greater than average numbers, to alcohol and other substance use, and other often harmful self-medicating activities, in efforts to mitigate symptoms and to contain their underlying issues from exposure and treatment. Despite considerable investments by police services in their human resource departments, employee and family assistance programs (EFAP), and many other supportive options, many will avoid such doorways out of fear of exposure.

Too often, by the time their condition either forces them to seek help of their own accord, or is recognized by others or by consequences that leave them no choice but to seek help, they will have already traveled well down all three of the pathways described above. They may be at a point of greater criticality in their mental health issues. They may have a narrower range of secondary prevention and care options available to them. And, with surprising frequency, they may be experiencing disconnection due to damaged relationships with their employer, their colleagues, their friends, and their family as a result of their unmanaged illness and/or their unhealthy reliance on intoxicants.

## The High Costs of Accommodation

In the best cases, members who recognize or are recognized early for mild to moderate mental health conditions will be quickly and effectively connected to the professional services and guidance they require. Enter the high personal costs and heightened risks that stem from accommodation. This is a term, and a status, that can be almost as loaded and stigmatized as mental illness itself in the policing culture.

If you are being accommodated by the organization, there are very differing responses that might apply. If you are still able to come to work and execute tasks that remain central to the mission, you are still serving your calling. Even if there are restrictions placed on your attendance, your deployment or your range of duties, and others know this to be due to a temporary or even permanent physical injury or illness, you may still be regarded as a dedicated and courageous member for continuing to serve when and where you can.

But, something appears to change if the reasons for modified duty or extended absence from work are left open to speculation and rumour, as can often be the case when a member chooses to remain private about mental health issues they are experiencing, or about the nature of their treatment and path to recovery. Stigma and misinformation about mental health care and recovery can lead to harsh and even hostile presumptions among peers, supervisors and managers that a member's behaviour is simply malingering, especially where there have been past performance issues or workplace conflict. This despite evidence that real malingering is actually quite rare. And, to quote one demeaning descriptor used by some, a member has been reduced to "counting paper clips" if a reassignment falls far outside their usual scope of duties, notwithstanding that it is still significant and dignified work.

Again, it is easy to see how quickly and how much further a member being accommodated for mental health reasons under these prevailing conditions might travel down those three pathways. Some may deny their own conditions completely, or deny themselves access to the care and treatments available due to self-stigma and cultural perceptions. Even if receiving care, the motivation will be very strong to suppress symptoms, to exaggerate wellness, and if accommodated or absent, to push hard toward full reinstatement, thus risking an increase in the criticality of the underlying mental health issues. The tendency to eschew available supports and services will be a common tactic to remain unrestricted in one's duties. If performance issues or conflicts with supervisors begin to surface, it may be without the benefit of true explanation. And, these additional stressors and ongoing deceptions at work and at home will often continue to deepen other actual and emotional disconnections from family and friends, especially when substance use also increases as a chosen means of coping.

## The Give and Take of Post-Traumatic Stress Disorder (PTSD) Presumptive Policy in Ontario

An operational stress injury (OSI) is a non-medical term that is generally defined as "persistent, psychological difficulties resulting from operational duties" . Within a broad category of operational stress injuries related to policing, a number of mental health issues can be described as post-traumatic stress injuries (PTSI), including depression, substance use disorder, and specifically, the clinically diagnosed condition Post-Traumatic Stress Disorder (PTSD). With increasing acceptance and reduced stigma as a result, operational trauma is rapidly becoming the exception that breaks the rule, when compared to police attitudes on mental health in general. This is a positive development in and of itself.

---

<sup>4</sup> Public Safety Canada (2019). [Post-traumatic stress injuries and support for public safety officers.](#)

The Ontario legislature passed presumptive legislation in 2016, expediting access to Workplace Safety and Insurance Board (WSIB) benefits, and by extension access to care for members who have been diagnosed by a psychiatrist or psychologist. It is no longer necessary to establish a causal link between a specific traumatic event and the condition. There is little doubt that this step has brought many more police officers to the care they require while also reducing the burden and added stressors of justifying their condition on the basis of a single traumatizing experience.

However, the panel observed two difficulties that have arisen, perhaps as unintended consequences from this progressive policy. The first is that WSIB and clinicians are still required to adjudicate the general pattern of trauma in order to exert some measure of control over the uptake of these benefits and services. As such, while a single precipitating event might not be required, some police officers experiencing symptoms of PTSD might still find themselves trying to justify their basis, and if unsuccessful and benefits are denied, to pull away from the care they require due to cost and now worsened self-stigma.

The second concern is that while the presumption opens a path to care for PTSD, it may inadvertently be closing down other paths to care for more generalized mental health conditions, including the broader range of occupational stress injuries. This can lead to misdiagnosis and over-diagnosis of PTSD on the one hand, since that is where the benefits are most accessible, and it can leave those experiencing such conditions as depression, anxiety disorders and substance use disorders without similar access and/or self-justification, on the other.

There is no doubt that trauma is a real and present danger in police work, and recent research is revealing more about and reducing stigma around the genuine nature of OSI's being experienced by military veterans and first responders across the board. However, just as PTSD is gaining legitimacy as one condition, our panel recognized the potential risk of narrowing the lens through which we view the entire spectrum of mental health challenges to which police officers may be prone.

## **The Confounding Interplay among Workplace Stressors and Life Events for Police**

It seems likely that any person who experiences a decline in their mental wellness might struggle to distinguish the roles played by the stresses of everyday living versus those that have come from earning a living. Nonetheless, our panel observes that there is an interplay among these sources that may be even more complex for police than for others. As our nine subjects traveled down those three pathways to their tragic point of convergence, most had become disconnected from their employer and organizational supports, and at the same time, most were also disconnecting from their family, friends and social supports, if not in actual terms, then certainly to significant degrees of emotional detachment. The inherent danger in this observation is that one might be easily inclined to attribute their condition to on-the-job trauma and/or workplace dynamics, and miss the corresponding stressors playing upon them from their interpersonal conflicts, economic challenges, and other stressors of everyday life. Or, since in most of our cases and others we reviewed the most apparent precipitating events actually derived from outside of work, it would be just as easy to ascribe their state of health to everyday life alone, and to discount the roles played by their career-long experiences.

What makes this dilemma important in the context of policing is the interwoven nature of police identity as described above. Many police members have described the difficulties they face in even recognizing the distinction between work life and home life. The difference between on and off duty for a police officer is merely a distinction of pay and equipment because in Ontario, once sworn, a police officer carries his or her authorities and responsibilities 24 hours a day. Since they tend to see themselves serving and defined by a calling, and they

operate tightly within a team culture that is unique in society for its rights and its responsibilities, their identity tends to travel with them. Many have described the way their children, spouses and significant others view them as heroes. As such, disappointing one's colleagues on the job may also be, in their own perception, to disappoint those others outside of work and to fall short of that important identity for everyone.

## **An Enduring Commitment to Duty Despite the Personal Costs**

Our final observation on the peculiarities of the policing context requires a disclaimer: neither a study of police deployment options, nor a full appreciation of the economics of policing fell within our scope. We did recognize that like all public services, police budgets must be managed and sometimes resources must be constrained.

Nonetheless, it appears to us as a panel that police resources in Ontario are strained to a breaking point in many locations around the province. It follows that mental health impact can be expected to continue and perhaps even grow in frequency and intensity if this situation is not somehow addressed.

These resource shortages may be real or perceived. They may be due to an inability or unwillingness to implement new models and re-engineered practices as some might suggest. They may be due to an unwillingness of local, provincial and federal governments to meet the real budget requirements as others would argue. They may be due in part to a vicious circle where each new accommodation of a member with mental health issues further aggravates already diminished staffing levels. But, while decision makers grapple with these arguments, police members are burning out, many are becoming ill, and some are dying.

It is in their nature to keep coming to work. It is in their nature to deploy into harm's way even when understaffed. It is also in their nature to minimize and suppress their own symptoms until they can no longer do so.

## Part Three: Seven Pathways to Better Outcomes

Earlier, we identified the three converging pathways that each of our nine subjects traveled to the ultimate point of their tragic deaths by suicide. Throughout our deliberations, we also uncovered seven new pathways that we believe will point the way to better outcomes for all police members in the future.

In Appendix A to this report, we list a number of specific recommendations, and where appropriate, we also identify potential roles associated with each.

In this section of our report, we will first discuss these pathways as they emerged for us as clear themes for action, as areas of opportunity, and as new ways of understanding and approaching the challenges outlined above. These themes are cross cutting in nature, and many of our specific recommendations derived from several of these pathways to change. They are discussed here in no particular order of priority. In the view of the panel members, every one of them will play an important part in any comprehensive plan of action.

### 1. Normalizing Mental Health Challenges

Removing stigma from mental health in general society is an important goal for everyone. In policing, it is a goal that must be recognized and acted upon as an urgent priority. The goal must be to make mental health as normal a subject as any other form of health, wellness and fitness for duty. To be effective, this normalization must begin prior to recruitment, it must extend through basic training at academies and remain evident in on-the-job orientation training with well-prepared coach officers. It must continue throughout policing careers, and it must extend to include the families and significant others of police service members at every stage.

Family members can play vital roles in the recognition, management and support of mental health issues at every stage of prevention and treatment, but only if they are included in an open conversation from the outset and gain continuing knowledge and awareness of what to look for and how to respond.

Current attitudes about mental health issues among serving police members at all levels represent a clear and present danger. It matters not whether these attitudes have derived from general society, or have been cultivated within police ranks through their prolonged exposure to mental health crises and the suicides of others to which they frequently must respond. Policing as a system must transition to a point that their own mental health risks, mild to moderate mental health issues, and advanced mental health conditions are recognized early and acted upon consistently with the support of accessible care and suitable services. For this to occur, mental health in policing must come out of the shadows.

We believe much can be gained by linking mental wellness

---

#### **Panel Observations on Current Strengths & Weaknesses in the Police Mental Health Ecosystem**

##### **Access to Appropriate Care and Treatment**

Privacy and Fear of Career Repercussion  
Many care and benefit paths begin with the human resources unit of the member's police service. Many members fear reputational damage from disclosing their mental health issues to fellow employees and members of organizational management.

For the panel, for police services and police association officials, for health professionals, and most notably for the surviving families, it is an alarming and unacceptable number.

*cont. next page...*

---

to peak performance, a concept that most police officers recognize and value. This will require taking conversations and training events well beyond 'mental readiness'. Such events must also include a greater awareness and understanding of the secondary and tertiary prevention and care models that are available. They must demonstrate that even broken toys can be repaired, and that the path to recovery will be fully supported without diminished identity and without marginalization from the core mission of policing.

We envision that a broad and multi-faceted campaign will be necessary to bring about this transition. In many ways, it is already underway as reflected in our own review and others occurring in parallel, and in the promising initiatives undertaken by Ontario police services and their varied associations. But in our view, it must be scaled up and amplified. Openness, awareness and supportive behaviours toward fellow members experiencing mental health issues should become essential competencies tied to performance and promotion systems at every level, and other forms of recognition should also be explored.

It has been said that police officers are prepared to die for one another. They must also be prepared to live for one another, and at the same time, to live fully for their families and friends without suffering in silence.

## 2. Navigating Through Transitions

When it comes to mental health issues in policing, the devil seems to lurk in the transitions. Our studies revealed consistently that some of the greatest risks for interruptions in care, for denial and suppression of symptoms, and for aggravated levels of stress tend to occur most during pivotal transitions in an individual's deployment status in the workplace. Critical transitions may include: periods of repeat short term absence necessitated by mild to moderate symptoms, whether diagnosed or not; initial disclosure and while applying for benefits and psychological services; reassignment to modified roles due to conditions affecting fitness for duty; reassignment back into full service; and, periods of extended leave due to escalated conditions and/or to access more intensive levels of care and treatment.

Of all of these transitions, return to work (RTW) stands out as the point of greatest risk. The complex decision-making processes about returning to modified duties or to full

### Access to Walk-in Support

Access to Walk-in Support  
Some agencies have introduced independent staff and outside psychologists and some have established out-of-office locations for walk-in support without risking disclosure. Relatively few police services currently offer this option.

### Limited Access in Small Urban, Rural and Remote Settings

Smaller police agencies may lack the resources to provide support-with-privacy options for their members. As well, smaller communities may have limited clinical resources, requiring significant travel and potentially more absences from work for those seeking assistance.

### Benefit Limits

Some member associations (OPPA and Ottawa Police Association) recently negotiated no-limit arrangements with their benefits providers. In most Ontario police services, there are restrictive limits on the length of care provided under existing benefits and insurance schemes, and co-pay costs vary significantly.

WSIB claims face ongoing pressure to reduce or restrict uptake, duration and cost, and often require extensive efforts by member and families to justify the need for care, treatment and compensation for absence from work. An additional barrier is the requirement to be seen by only WSIB approved treatment providers. The WSIB payment scheme is generally paid at a much lower rate than market.

*cont. next page...*

reinstatement can generate significant stress for individuals, their families, their co-workers, their care providers, and their benefits administrators including the WSIB. Among our nine subjects, RTW factored heavily and frequently into their worsened health conditions, triggered open conflict with their organization and peers, initiated or aggravated performance and professional standards issues, and often led to financial stress.

Further aggravating these stressors is the current fragmentation that individuals and families must navigate. Certain services and supports may be available from the employer, while others may be provided only through their Police Association. Individuals may be directed to some services by independent peer support workers, by benefits and EFAP providers, and by clinical care providers. Some of these same agencies may provide 'system navigator' supports. But, experience has shown that rarely do such navigation supports cross the full spectrum of clinical guidance, procedural assistance, and educational programs to help the individuals and families affected.

A full scope of navigation supports should be readily available to all members in all police services, built upon consistent best practices, yet remaining flexible to the needs of each individual, family, and police service involved.

### **3. Continuing Access to Quality Care with Evidence-based Treatment and Solutions**

Based on our lived experience sources including the voices of survivors, the confidence level among police members and their families in the current patchwork of care providers is at best moderate to low. We heard of service professionals with little to no familiarity with policing or first responder issues, including the role played by recurrent trauma. We heard of others who initially established a strong connection with their patient, only to later refuse to continue providing care under established benefit fee schedules. And, we heard of well-qualified and policing-knowledgeable professionals who established strong bonds and achieved successful outcomes with their patients.

Given the often fragile state of any police member who is coming to terms with symptoms or with a mental health diagnosis amid the cultural dynamics described earlier in this report, any barrier to access can be a reason for them to revert to suppression, denial and withdrawal from care. For some of our nine subjects, the last years and months of their lives

#### **Availability of Trauma and Police-informed Clinicians**

When seeking treatment, members face limited availability of practitioners who are familiar with the unique demands of police work and the role of trauma in mental health issues. No universally reliable reference source currently exists, though some are under development.

#### **Inconsistency in Peer Support Models**

Volunteer-driven police and first responder peer support providers have emerged in the past few years, and many are seeing demand grow for their services. Currently, peer support practices and service offerings are viewed to be inconsistent in scope, quality, and integration with other MH services.

#### **Balancing Affordability vs. Quality of Treatment**

When faced with benefit limits, or due to fear of disclosure to their employer and colleagues, members and their families often struggle to access and sustain affordable care paths, often forced to choose between high quality care and treatment for a very short duration, or questionable care over a longer period of access. Many simply withdraw from this challenge and elect no continuing care.

*cont. next page...*

were clearly punctuated with stop-start patterns in their care path. For others we heard from, their descriptions of their own care paths ranged from successful, to frustrating, to futile.

It is imperative in our view that access to quality care become universal among police members in Ontario, and the quality of care options must extend to include policing and trauma informed clinicians and the application of evidence-based treatments and solutions. It is our understanding that some of the volunteer agencies and police associations in Ontario have begun to establish referral lists of suitably qualified professionals and support networks. This work should be accelerated and made widely available as soon as possible.

#### 4. Resourcing, Accommodation and Burnout

For most municipal police services in Ontario, Police Service Boards are responsible to maintain adequate staffing levels to meet demand for service in their jurisdiction. For the OPP and First Nations police services, this responsibility rests with the provincial and federal governments. Most police budget-setting processes establish an 'authorized strength' of members. The authorized strength model is built on the premise that all the police positions are filled and all members are at work. The model does not adequately take into account that staffing vacancies occur when recruitment numbers fall short, and also when members are away from the workplace on medical leave. This gap translates to an additional workload for members who are working. Through intensified workload demands in regular deployment, and often through increased overtime levels, essentially it falls to the members to subsidize the shortfall in the authorized strength.

The repercussions of this model are that those left working are forced to function in an environment where they are short-staffed which may lead many to burnout. Some may also develop a feeling of contempt toward members that are on medical leave. And, all of this leads to further erosion in the identity issues occurring for those absent members.

Under the current model, staffing gaps contribute to an ongoing systemic deterrent to disclosure of mental health issues, create a significant barrier to those who need to access and maintain proper care paths, and uphold a false expectation of fit-for-duty capacity that perpetuates stigma and self-stigma surrounding mental health and occupational

#### Availability of Supportive Care for Family Members

Currently, family members are very often excluded from the care path of their loved ones dealing with mental health issues. It appears that this is may be due to a lack of information about options available, lack of knowledge about mental health in policing, real or perceived privacy concerns, or it may be a symptom of the member's disconnecting behaviour.

#### System Navigators & Patient Advocates

When police members find themselves in crisis they are often required to navigate unfamiliar and complex processes which can be a barrier to care, while also having a detrimental effect on the member's well-being, especially for those already reticent to disclose. Some members and families may also incur financial strain by paying for expenses which may be eligible for coverage. A full scope of system navigator supports will span clinical, educational, and financial challenges.

#### Internal Attitudes, Behaviours, Knowledge and Skills

#### Unwarranted Perceptions of Malingering

Despite recent investments in mental health awareness and resilience training, suspicions and even outright accusations of malingering remain common in policing culture. Evidence shows that incidents of malingering are rare, and in most cases, the requirement for care and accommodation is very real.

*cont. next page...*

stress injuries. The reality of staffing gaps must be confronted. Each individual police service will undoubtedly continue to face fiscal pressures, and in the short term at least, most may be unable to resolve their current staffing gaps on their own. Attention should be given to acting collectively to establish a province-wide system for exceeding authorized staffing that will allow for sufficient resourcing to fill vacancies when members are away from the workplace on medical leave.

## 5. Preserving Identity: The Criticality of Criminal or Police Act Charges and Social Media

The RTW transitions described above represent the most frequent high-risk points for police members with mental health issues, but situations where officers face charges and/or public embarrassment through mainstream or social media could be described as the most acute. In our review of deaths by suicide, if not managed with care these ‘hand-off’ situations can clearly rise to the level of a precipitating event with an impact equivalent to the loss of a primary personal relationship.

Recognizing the significant role that police identity has for members deeply invested in policing culture, police services have a special responsibility to ensure that any sudden and extreme damage to that identity is managed with care and support. We reviewed situations and practices where special hand-off arrangements are in place and applied to ease the negative consequences. Among our nine, we also reviewed some situations that, whether intended or not by the service, were experienced by the subject member as outright abandonment. We reviewed others that fell somewhere in between.

Every police service must take on the responsibility to establish and apply hand-off procedures that will ensure that no matter the severity of a member’s infraction or breach of duty, or whether the scope of any disciplinary action contemplated is seen as a minor set-back or a career-ending criminal charge, supports will be in place to maintain a connection to the member and his or her family, and to ensure a continuity of professional care as may be required.

## 6. Managing Suicide Events

We cannot manage, improve or learn from things we do not know about. As important steps towards improving outcomes

### Limited Knowledge among Supervisors & Managers about Treatment and Recovery

Anecdotally, many police managers, supervisors and peers continue to regard mental health conditions as a permanent disability. Awareness of the true nature and success rates of treatment and recovery would greatly improve return-to-work transitions for members who have experienced a mental health issue, thereby aiding in stigma reduction

### Limited Creativity and Sensitivity in Assigning Accommodated Duties

The binary ‘fit for duty, or not’ attitude described elsewhere in this report continues to influence decisions on modified duty. Members report the negative impact on their dignity from reflex assumptions about the limits of their ability to perform and to remain tied to the core mission with which they identify strongly.

### Unclear Guidelines on Privacy and Connection During Accommodation

Supervisors, managers and peers report being uncertain of if or how they might maintain a connection to their colleagues who are absent from work due to mental health issues. This is further aggravated if professional standards issues are also involved. Greater clarity, established guidelines around consent, and the development of compassionate, trauma-informed skills would be of significant benefit in this regard.

*cont. next page...*

for all police members in Ontario, all coroners should be directed to record and report on any death by suicide of a first responder, a database should be established to permit ongoing data capture and analysis, and any death by suicide of a police member should trigger a death review in the Office of the Chief Coroner. In our view the unique nature within, and the place of policing in society, requires that we closely track and learn from every situation that results in a death by suicide, with a view to continuous improvement across the entire police and mental health ecosystem.

Much of the foregoing discussion has centred on opportunities in the prevention and intervention stages of mental health. Postvention is also recognized as a best practice in suicide prevention, and there are two aspects to it that warrant priority attention and action from our review. One of these involves extending caring support to the bereaved, including direct actions to prevent collateral mental health conditions among family members, close friends and associates, and the other addresses the need to minimize the risks of a contagion effect across the policing community.

In the first, we note that among the survivors of our nine, some degree of bereavement support from their loved one's employer, association, and colleagues was evident in most cases, but it can best be described as uneven in its execution, its scope and its duration. When properly planned and constructed, postvention practices are designed to achieve a number of aims in the aftermath of a death by suicide, specifically to:

- prevent suicide among people who are at high risk after exposure to suicide;
- facilitate the healing of individuals from the grief and distress of suicide loss;
- mitigate other negative effects of exposure to suicide; and,
- in a policing context, some means to respectfully memorialize the deceased.

All police services should have a prepared organizational response plan for postvention services designed to assist the bereaved in managing the immediate crisis of a death by suicide and coping with its long-term consequences.

With regard to the broader community, there exists in the literature some evidence of a risk for contagion effects. In other words, particularly among others in the same population group who may already be experiencing mental health challenges, one or more suicides in that same group may have a triggering effect. Clusters of deaths, as seen in our nine cases in a single year, certainly heighten concerns in this regard. It is important to note that the contagion need not necessarily amount to additional suicides for us to be concerned. The potential to exacerbate the mental health issues of any police member or group of members is also worthy of our concern.

Postvention is a critical part of suicide prevention, and can also be part of a comprehensive strategy for mental wellness in general. Ensuring that postvention activities take place after any police member suicide should not be the responsibility of one group, one police service or one individual. This will require a whole-of-community commitment.

---

### **Balancing Workload Pressures vs. Compassionate Support**

When entire police organizations are under strain due to limited deployable resources, the pressure to return members to full active duty often overrides compassion for the individual, and reduces active support for their continuing accommodation and care.

---

## 7. Joint Ownership and Collaborative Action

Our police and mental health ecosystem model shown earlier in Figure 3 illustrates both the scope of resources and capacities that currently exist to lend support to positive outcomes in police member mental health, as well as the complexity and potential for fragmentation that currently exists across this system (see Sidebar above). We also noted earlier the range of promising initiatives and policy considerations that are underway to bring improvement to the level and quality of services at every stage of prevention, intervention and postvention. Our deliberations led us to some concern that if left unchanged, continued fragmentation may undermine much of this promise.

Policing as a system must adopt a no-wrong-door mindset in order to ensure that every member and family affected by mental health issues, at their earliest presentation, faces no barriers in seeking out, accessing, and affording the care and treatment they require. To fully achieve this, policing must act as the unified system that it is in the eyes of its members.

We recognize recent collaborative undertakings among the OPP, its associations and its not-for-profit partners as one promising model, but little will change if that same approach is not replicated across the remaining police services that serve Ontario communities. Similarly, we were encouraged by collaborative discussions described by the OACP and PAO, and by TPA with its employer partner the Toronto Police Service. We also recognize that member mental health has become a priority agenda item for the Ontario Association of Police Service Boards (OAPSB), as it has nationally with the CACP, the Canadian Association for Police Governance (CAPG) and the Canadian Police Association (CPA). But, in our view there is a growing risk of lost effectiveness and efficiency from an emerging patchwork of bilateral and multilateral initiatives taking shape, without the full involvement of all parts of the ecosystem moving in common directions.

In Ontario, we believe the Ministry of the Solicitor General, guided by this report to the Ontario Chief Coroner, is best positioned to provide the essential leadership and mobilization to achieve a whole-of-system approach. We address this opportunity as the first of our recommendations for action in our Appendix A.

## Part 4: A Much Broader Legacy

Taken collectively, these seven pathways encompass a range of opportunities for a whole-of-system solution to a very real problem in policing that extends well beyond and well ahead of any specific occurrences of death by suicide.

We hope that police and association executives, boards, and mental health service providers will embrace these opportunities and work together on the specific actions we propose below. We believe a new policing culture can emerge where the full cycle of prevention, recognition, appropriate disclosure, care and treatment, recovery and reintegration can occur with greater openness, greater success, and without repercussion to anyone facing mental health challenges whether due to operational or organizational stressors, or from any other cause inside or outside of work.

And, we hope that every police member, sworn and civilian, will bring the same courage that they bring every day in service of others, to embrace and thrive in this new and more open culture. We hope that current and future members will remain visible so that others can assist them, and will remain fully connected to their families and friends as well as to the calling they have chosen. We know it is a calling they value, for life.

Finally, we hope the foregoing discussion and the 14 specific recommendations that follow below will inspire the comprehensive and collaborative action on police member mental health that is urgently required in Ontario.

## Part Five: Our Recommendations for Action

1. The Policing Services Division of the Ministry of the Solicitor General (PSD-MSG) will lead the development of an Ontario Police Members Mental Health Collaborative (OPMMHC) as a standing body accountable to the Deputy Solicitor General, to meet quarterly on a continuing basis and to operate under the following initial terms of reference:
  - a) OPMMHC will be comprised of qualified volunteer representatives from police service boards, police service executive management, police associations, police supervisors (sworn and civilian), police members with lived experience, police family members with lived experience, police psychologists and other mental health providers with expertise in policing, researchers, peer support groups, and insurance and benefits providers;
  - b) OPMMHC will be co-chaired by one representative of police executive management and one police association executive;
  - c) OPMMHC will serve in a steering and coordinating role to identify and act to resolve gaps, overlaps and service deficiencies in order to improve the effectiveness, efficiency and universal accessibility of mental health supports to police service members across the province;
  - d) OPMMHC will establish and disseminate appropriate benchmarking tools and metrics, establish implementation timelines, report semi-annually on progress of recommendations in this report and from other sources, and execute other initiatives as OPMMHC members may determine;
  - e) OPMMHC will develop an agenda of priority research topics for policing in Ontario, including encouraging the development of a police specific interpretation of the CF-modified Mann model for suicide prevention depicted in Figure 1 of this report, incorporating any additional factors and interconnections addressed within this report.
  - f) MSG will provide administrative support and base funding sufficient to sustain the meetings of the OPMMHC;
  - g) OPMMHC projects will be otherwise staffed and resourced through in-kind contributions from the participating members;
  - h) and, other terms of reference as PSD-MSG and the participating OPMMHC stakeholders may determine.
2. The OPMMHC, once established, will lead the development of a Communications Sub-committee (OPMMHC-Comms) dedicated to the design and ongoing execution of a broad campaign aimed at normalizing mental health challenges, reducing stigmatizing behaviours and assumptions, achieving healthier identity and work life balance, and building awareness of supports, treatments and recovery outcomes in all police services, police academies, and police-related program units in Ontario Community Colleges and Universities;
  - a) OPMMHC-Comms will be staffed on an in-kind, part-time basis by Ontario police services, and supported by PSD-MSG with additional funding on a project-by-project basis, as required;

- b) The normalization campaign will be available for province-wide roll out by December 31, 2020.
3. The OPMMHC, once established, will lead the development of a Knowledge Translation Sub-committee (OPMMHC-Education) dedicated to accessing, interpreting, adapting and disseminating best practice education and training resources for mental health and suicide prevention to all identified end-users (including police members, leadership, families, peer supporters, clinicians and the general public) from available sources, including universities, governmental and non-governmental organizations such as the Canadian Institute for Public Safety Research and Treatment, the Canadian Institute for Military and Veteran Health Research, the Public Health Agency of Canada's PTSD Secretariat, Veterans Affairs Canada, the Department of National Defence, and other police professional organizations and stakeholder groups;
    - a) The Knowledge Translation Sub-committee will be well developed and materials will be rolling out province-wide by December 31, 2020. There will also be provisions for measuring application and retention of new knowledge by the end-users, continuous improvement, and updating of materials as needed.
  4. OPMMHC will work with Ontario police services, peer support agencies, insurers and clinical providers to establish clear guidelines for the qualifications and standards necessary to provide clinical care and peer support services to police members.
  5. OPMMHC will produce by January 1, 2021 a single, consolidated and living referral source outlining the availability of suitably qualified care providers and treatment options in all regions of the province.
  6. OPMMHC will work with all partners to advance a no-wrong-door policy across the province, with a view to reducing administrative and funding barriers to members in need of immediate access and care.
  7. PSD-MSG will direct all police services in Ontario to develop and implement a comprehensive mental health (MH) and wellness strategy by June 30, 2021;
    - a) Comprehensive MH strategies will include local normalization initiatives; provisions for ensuring access for their members to suitable evidence based and qualified prevention, self-care, intervention, and postvention supports;
    - b) Comprehensive MH strategies will also include training and education initiatives, as informed by OPMMHC-Education, designed to meet the needs of recruits, members, coach officers, supervisors, managers, human resources specialists, peer support providers, mental health professionals, and families;
    - c) Comprehensive MH strategy elements may be provided directly by a police service, through partnerships with other police services, and/or in partnership with third party providers, as required;
    - d) Comprehensive MH strategies will provide for engagement of family members in learning and discussion sessions and other activities related to police member mental well-being during the recruitment process, at critical transition points (as defined in this report), and periodically throughout policing careers;
    - e) Comprehensive MH strategies will include the establishment of specific competencies and performance expectations, related to maintaining and supporting mental wellness and/or responding to mental health issues, for all members in general, and specifically for supervising members, and will be incorporated into promotion, performance management, and recognition systems by December 31, 2021.

8. OPMMHC will assist and guide police services in establishing web-based Members and Families Mental Health Portals, service-specific for larger services and/or general access for all services, to make available information and resources to support open and informed conversations about mental health and well-being. Portals will be established and accessible to all services by June 30, 2021.
9. OPMMHC will guide the development of best practice guidelines for managing all mental health related accommodations and return-to-work (A-RTW) decision processes by December 31, 2021;
  - a) A-RTW processes will include collaboration among management, human resource specialists, members, families, associations, insurers and third party clinical advisors, with clear roles and responsibilities established for each;
  - b) A-RTW processes will include specific guidelines for maintaining supportive connections with accommodated members and those who are absent from work, and with their families when permitted.
10. OPMMHC will guide the development of best practice guidelines for managing all high-risk 'hand-off' support processes by December 31, 2021;
  - a) Hand-off processes will apply to any situation involving or with the potential to involve Police Service Act charges, criminal charges, removal of use-of-force options, or member identification and negative attention from mainstream or social media;
  - b) Hand-off processes will include specific guidelines for maintaining supportive connections with accommodated members who are absent from work, and with their families when permitted.
11. PSD-MSG will encourage more police services in Ontario to hire mental health professionals to the extent affordable on their own, or in partnership with neighbouring police services.
12. The Ontario Association of Chiefs of Police (OACP) will be encouraged by this report to establish a provincial parallel to the CACP's Psychologist Sub-committee to facilitate greater cooperation, capacity, and the development of Ontario-specific best practices.
13. PSD-MSG will encourage more police services in Ontario to adopt, if they have not already, police mental health partnerships along the lines of COAST, PACT and similar models across Canada, and Project ECHO in the USA, in order to improve relationships and interactions between police and persons with mental health issues in the community, and to further normalize member awareness and knowledge about mental health prevention, treatment and recovery.
14. The Office of the Chief Coroner (OCC), in partnership with others as required, will seek to establish policy in Ontario that requires all coroners to report and share information on any death by suicide of a first responder, including police, and to initiate a death review committee in all such cases;
  - a) The OCC will lead the development of a suitable system for capturing data from all such deaths by suicide and resulting death reviews;
  - b) The OCC will lead the design and development of analytic tools, through consultation with OPMMHC and others, to learn from cumulative deaths by suicide with a view to identifying opportunities for continuous improvement in the first responder mental health ecosystem.

## Appendix: Members of the Chief Coroner's Expert Panel

### **Dr. Lori Gray**

Dr. Gray is a clinical, forensic, and rehabilitation psychologist whose focus has been best practices and progressive approaches in early intervention and comprehensive care through her work with multiple emergency services and peer support programs. She is currently based out of private practice in Barrie, ON and works with first responders and emergency services across Ontario. Her background includes diverse experience as the psychologist for one of the largest paramedic services in Canada, Centre for Addiction and Mental Health, Detroit Receiving Hospital, Ministry of the Attorney General, Correctional Service of Canada, and postsecondary teaching.

Dr. Gray has received the Future Pioneers of Psychology Award from the American Psychological Association, Early Career Achievement Award from the Canadian Psychological Association Traumatic Stress Section, Odyssey Early Career Achievement Award and GLAD Award for Teaching and Mentorship from the University of Windsor, among other awards from agencies including the International Society for Traumatic Stress Studies, Canadian Psychological Association, and Social Sciences and Humanities Research Council of Canada.

### **Dr. Simon Hatcher**

Dr. Hatcher is a psychiatrist and researcher at The Ottawa Hospital Research Institute. He trained in psychiatry in the UK before working in New Zealand for twenty years and moved to Canada in 2012. He has been the principal investigator on several large randomized controlled trials of treatments for suicidal people. Clinically, he runs a First Responder Clinic at The Ottawa Hospital and has received research funding to investigate the preferences of First Responders for mental health care and to test different ways of screening for mental disorders in first responders.

Dr. Hatcher is a member of the Canadian Institute for Public Safety Research and Treatment (CIPSRT).

### **Lieutenant Colonel (Ret) Alexandra Heber**

Dr. Heber is the first Chief Psychiatrist of Veterans Affairs Canada (VAC), and an Assistant Professor of Psychiatry at the University of Ottawa. She was the VAC lead author on the CAF- VAC Joint Suicide Prevention Strategy. She has over 30 years' experience working in Mental Health. Dr. Heber served in the Canadian Armed Forces (CAF) and was deployed to Afghanistan as Psychiatrist in Charge of the CAF Mental Health Services for Task Force Afghanistan. Her military experience included a decade as Clinical Leader of Military Mental Health in Ottawa, then the establishment of the Section of Clinical Programs for CAF Headquarters, where she oversaw 30 CAF mental health clinics across Canada.

She has presented and published nationally and internationally on Post Traumatic Stress Disorder and suicide prevention in military, veteran, and first-responder populations. Her research interests include: suicide prevention, the military-civilian transition experience, and the role of peer support in military and paramilitary

organizations. She has authored 2 online courses on PTSD and trauma-informed care, one for Canadian physicians and one for the Newfoundland and Labrador Health Authorities, and she has authored a number of reports for the Justice Department, Government of Canada, on cases involving torture and PTSD.

Dr. Heber works on developing strong collaborative relationships among government, academics, research institutes, clinicians, military and public safety organizations, families and those with lived experience. She has received the Veterans Affairs Canada Leadership Award, the Canadian Armed Forces Chief of Defence Staff Commendation, the Queen Elizabeth II Diamond Jubilee Medal and the General Service Medal, South-West Asia.

### **Dr. Stephanie Barone McKenny**

Dr. McKenny is a police psychologist with the Los Angeles Police Department (LAPD) and provides consultation to several elite units including SWAT, Air Support Division, Criminal Gang Homicide Division, and undercover agents. She has worked with law enforcement personnel at the international, national, state, county, local, and university levels. Dr. McKenny is also a nationally certified sports psychologist and clinical trauma professional who applies peak performance skills in designing and implementing officer wellness programs, including the Mother of All Suicide Prevention Campaigns (which led to 25 months of 0 suicides at LAPD), the Resilience Task Force, the Substance Abuse Task Force, the Smart Detective, the annual Heart of LAPD Walk, and the pending Tactical Relief Checks.

As the spouse of a Navy Captain and the sister of a Lt. Colonel, Dr. McKenny understands at a very personal level the demands and sacrifices that police members make every day, and also the demands and daily sacrifice of their spouses, children, and extended family.

### **Serving Police Member**

This panel member is a currently active police sergeant who has served as a police officer in Ontario for over 30 years. His career includes over 25 years of front-line uniform policing assignments as well as six years of administrative and corporate experience.

While often described by others as a “high performer” and “go-to guy”, this member also describes himself as “someone who has suffered in silence for over 15 years while enduring the profession’s unrelenting exposure to critical incidents and traumas”. He is committed to leveraging his lived experience to create a legacy of preventing police suicides by improving police culture, eliminating stigma, and promoting mental wellness and resilience.

His fellow panel members are thankful for the courage and insight this member brought to our deliberations. His name is withheld here solely out of respect for his and his family’s privacy.

## **Angela Slobodian**

Ms. Slobodian is the Acting Director of Wellness at the Ottawa Police Service (OPS). As a registered nurse she has worked in hospitals and in public health. In 1994 she moved from her native Nova Scotia to Belleville, Ontario to begin work as an Occupational Health Nurse at a global telecommunications company, and this began her interest and passion in occupational health. She completed her diploma in Occupational Health Nursing and received her certification in 2002. She left the private sector company in 2009 as Director of North American Health Operations, moving to the Ottawa Police Service as Manager of Health, Safety and Lifestyles. As a nurse she has always had a commitment to health promotion and illness prevention.

The opportunity came to lead the development of a Wellness program at Ottawa Police, and Ms. Slobodian was pleased to take the lead. She currently has responsibility for the Health and Safety team and for the Peer Support and Resiliency program and OPS.

## **Clive Weighill, C.O.M.**

Chief Weighill (retired) is a veteran of policing in Saskatchewan. He served as the Chief of Police for the Saskatoon Police Service from 2006 to 2017 following his 31 years of service with the Regina Police Service, leaving that service at the rank of Deputy Chief. In September 2018, Mr. Weighill became the Chief Coroner for the Saskatchewan Coroners Service.

During his policing career Mr. Weighill worked in Patrol, Communications, Crime Prevention, Commercial Crime, Property Crime, Drugs, Vice, Planning and Research and Senior Administration. He also served as the President of the Canadian Association of Chiefs of Police (CACP) from 2014 to 2016. He is the recipient of the Police Exemplary Service Medal and Bar, the Saskatchewan Protective Services Medal, the Saskatchewan Centennial Medal, the Queen's Diamond Jubilee Medal, the Lieutenant Governor's Gold Medal for Excellence in Public Administration in Saskatchewan, and he is a Commander of the Order of Merit of the Police Forces.

## **Norman E. Taylor - Panel Moderator and Lead Writer**

Mr. Taylor has served Canada's policing community for over 25 years in his combined roles as an independent policy advisor, educator, researcher and author. Since 2014, he has organized and executed three national conferences on policing and mental health issues in partnership with the Canadian Association of Chiefs of Police (CACP) and the Mental Health Commission of Canada. In his capacity as co-founder and Program Director of the CACP Executive Global Studies Program, he has led global research studies on policing interfaces with the mental health system, and on some of the unique patterns and behaviours that shape the internal culture of policing. Mr. Taylor also provides strategic advisory and educational services to many police services, communities, and at all government levels across Canada and in the USA.

Mr. Taylor is a recipient of the Queen Elizabeth Diamond Jubilee Medal on nomination by the CACP, the Premier of Saskatchewan's Award for Excellence in Public Service: Innovation, and in 2018 he was proud to be named an Honourary Commissioned Officer in the Ontario Provincial Police.