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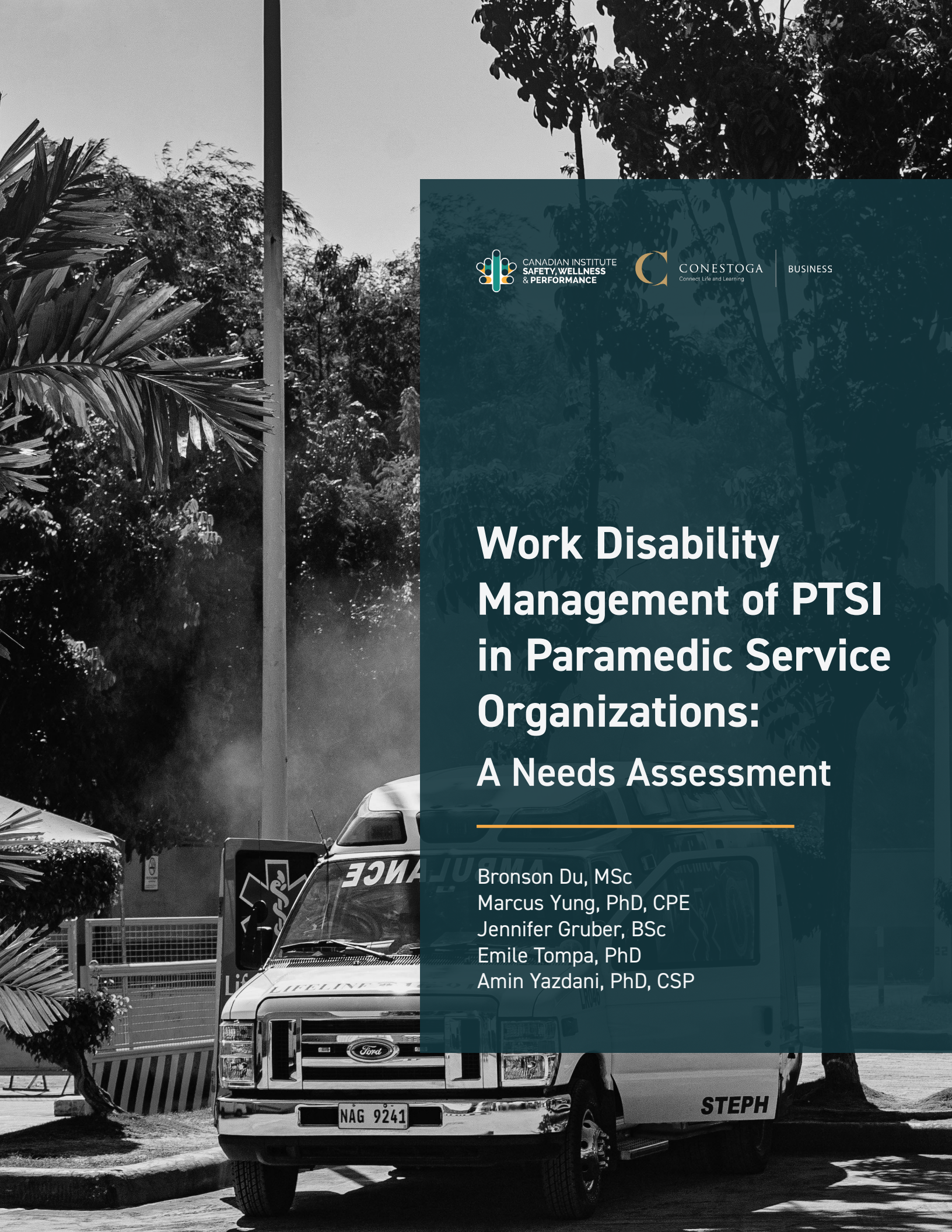
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BUSINESS

# Work Disability Management of PTSI in Paramedic Service Organizations: A Needs Assessment

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# BUILDING CAPACITY FOR PRODUCTIVE AND SUSTAINABLE WORK.



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# Executive Summary

## Objective

The objective of this needs assessment was to determine gaps and challenges between the current and desired conditions for addressing post-traumatic stress injuries (PTSI) in paramedic service organizations. Specifically, this study aimed to:

- 1) Identify what paramedics need from paramedic service organizations to address PTSI;
- 2) Understand how paramedic service organizations are currently addressing PTSI;
- 3) Identify challenges to preventing and managing PTSI at the organizational level; and
- 4) Provide recommendations that would address the identified needs and challenges while improving performance.

## Methods

We conducted semi-structured interviews with 11 key informants representing three stakeholder groups: 4 frontline paramedics, 5 supervisors and 2 union representatives. Interviewees represented services from British Columbia, Alberta, Yukon, Ontario, Prince Edward Island, and New Brunswick.

The duration of the interviews ranged between 68 and 148 minutes, with an average of 95 minutes. The interview questions were designed to understand the existing organizational initiatives and processes, the preferred situation for addressing mental health needs, and the challenges to addressing PTSI in the workplace. The interview guides were tailored to each stakeholder group.

## General Findings and Discussion

Significant strides have been made over the past decade to avoid and reduce the impact of PTSI amongst paramedics; there has been a noticeable shift in culture and the availability of resources. Our semi-structured interviews with key informants in the Canadian paramedic community revealed seven core elements for an effective and accessible work disability management system for addressing PTSI:

- 1) recognizing non-traumatic and chronic stressors as precursors to PTSI;
- 2) building and maintaining resilience;
- 3) stigma reduction;
- 4) supervisor support;
- 5) programs, policies and practices for managing PTSI;
- 6) additional time for recovery; and
- 7) early and gradual return to work with modified duties.

Each identified element is necessary but insufficient by itself to create an effective disability management system for the prevention and management of PTSI. Recommendations from this study will be embedded within the Canadian Work Disability Management System Standards for the Prevention and Management of PTSI in Paramedic Organizations to ensure synergistic application of the core elements.





# Introduction

In Canada, there are over 30,000 paramedics who provide emergency medical services (EMS) and secure public safety during times of crisis (Public Safety Canada, 2019). Unfortunately, many paramedics' capacity to perform their duties is hindered by post-traumatic stress injuries (PTSI), a mental injury that is a direct result of their line of work. In fact, a recent Canada-wide survey found that 49% of paramedics screened positive for at least one mental health disorder. This is almost five times higher than the frequency of positive screens for the general Canadian population, which is about 10% (Carleton et al., 2018).

The alarmingly high rates of PTSI among paramedics may not be a surprise when workplace exposures are considered. Essential tasks include, but are not limited to, long shifts of patient care, patient transport, and patient handling in various environments and circumstances, often during a crisis. In combination with high work demands, paramedics have little to no control of when they are dispatched in terms of who they are going to treat or where they are going to perform patient care and handling duties. In addition to the high demand and low control of their work, paramedics often suppress their emotions in order to perform their duties in a calm and professional manner. Paramedics may encounter traumatic events daily (Jones, 2017). Tending to traumatic calls, such as deaths by suicide, infant deaths, or multiple casualties, increases the risk of PTSI (Dobson, 2010; Public Safety Canada, 2019). Many of these risk factors are inherent to paramedic work and cannot be eliminated, but proper disability prevention and management can reduce their impacts.

While guidelines are available for implementing and operating standalone programs for PTSI, there is little guidance available on how to integrate and coordinate PTSI prevention and management programs into a paramedic service organization's management system. In 2018, the CSA Z1003.1-18: Psychological Health and Safety in the Paramedic Service Organization was developed "to provide paramedic service organizations and other key stakeholders with requirements and guidance on good practice for the identification and assessment of hazards and management of psychological health and safety risks for paramedic service organizations and the promotion of improved psychological health and safety" (Canadian Standards Association, 2018). To complement this standard, the overarching aim of this report is to inform the development of a standard that provides the framework for paramedic service organizations to successfully coordinate and integrate PTSI prevention and management initiatives into their work disability management systems. A new Canadian Work Disability Management System Standards for the Prevention and Management of PTSI in Paramedic Organizations will provide an evidence-informed framework with programs and practices to build resilience, reduce the stigma of PTSI, facilitate early detection and intervention, and support timely work re-integration and accommodations.

In this report, the term PTSI is used as a "non-clinical term that encompasses a range of mental health injuries, including some operational stress injuries, clinically diagnosed post-traumatic stress disorder (PTSD), anxiety, and depression. It characterizes symptoms as injuries caused to public safety personnel as a direct result of their work."

PTSD is a clinically diagnosed mental disorder characterized as an extreme reaction to trauma exposure. Symptoms of PTSD may include re-experiencing, avoidance, negative cognitions and mood, and hyperarousal (Public Safety Canada, 2019).

As a first step to developing the standard, we gathered and synthesized evidence using three methodologies:

- 1) an environment scan of recommended programs and practices for the prevention and management of PTSI amongst paramedics;
- 2) a scoping review of peer-reviewed literature on PTSI prevention and management programs and practices; and
- 3) a needs assessment undertaken via key informant interviews to identify current practices, challenges and needs of paramedic service organizations in addressing PTSI.

This report is the third of the three studies, the needs assessment. Needs assessments help inform program development and evaluation and are used when a new program is being developed, when an existing program is being modified, or when a program is being used in a new setting or with a new population (CDC, n.d.). Information is collected from a target population to develop solutions that match their needs and wants, and to determine whether the proposed program elements are likely to be needed, understood, and accepted. Needs assessments also help to ensure the intervention's feasibility to maximize the likelihood of successful outcomes (CDC, n.d.).

The specific objectives of this study were to:

- 1) Identify paramedics need in relation to the prevention and management of PTSI;
- 2) Understand how paramedic service organizations are currently addressing PTSI;
- 3) Identify challenges to preventing and managing PTSI at the organizational level; and
- 4) Provide recommendations that would address the identified needs and challenges.





## Methods

This needs assessment was conducted using semi-structured interviews with key informants. Key informant interviews are an effective qualitative method for gathering relevant information, ideas, thoughts and insights on a specific topic of interest in a short period of time (Marshall, 1996). It can be used as a stand-alone research technique or in combination with other methods (Marshall, 1996). Consequently, this method is well suited for the current work disability management system development initiative.

The study was approved by the Research Ethics Boards at Conestoga College.

## Study Sample

Frontline paramedics, supervisors, and union representatives were recruited to participate in the interviews. We define "paramedics" as the end-users of work disability management programs, so they have first-hand experience with the programs and can provide information on issues such as accessibility, efficacy, and implementation, as well as potential opportunities for improvement. Supervisors often serve as program coordinators, so they have valuable insights into how programs are coordinated and implemented.

## Data Collection and Thematic Analysis

Potential interviewees were identified via the research team's network and public websites. Additional potential interviewees were identified through snowballing technique. An information letter and consent form were first sent to potential participants via email. For those interested in participating in the study, a 90-minute telephone interview was scheduled at a time of their convenience.

At the start of each interview, participants were informed that the interview was being audio recorded. The interview questions were designed to be semi-structured and elicit an understanding of existing organizational initiatives and processes, the preferred arrangements, and the challenges of addressing PTSI in the workplace. Interview guides were tailored for each stakeholder group (see appendix A for the interview guides).

Audio recordings of each interview were transcribed and sent back to the interviewees to ensure the accuracy of transcription and to clarify statements as necessary. The transcripts were stored, organized and analyzed using Microsoft Word. The researcher (BD) reviewed each transcript two times using a thematic analysis approach. The first read-through served to identify recurring elements needed for addressing PTSI in paramedic service organizations, and the second read-through captured and classified relevant responses into their respective elements for interpretation. The core elements were then reviewed to ensure that they encompassed the entirety of the dataset and appropriately represented the responses in an organized and meaningful way.

After the core elements were finalized, extracts from interview responses were selected within each element to summarize the findings and shape the results. To maintain the confidentiality of the interviewees, only their occupational title such as "supervisor," "paramedic," or "union rep" was used in combination with a unique participant number.





# Results and Discussion

A total of 11 key informants were interviewed from various provinces in Canada. Interviewees included: 4 paramedics, 5 supervisors, and 2 union representatives. Interviewees represented services from British Columbia, Alberta, Yukon, Ontario, Prince Edward's Island, and New Brunswick. The interviews ranged from 68 to 148 minutes, with an average of 95 minutes.

Seven core elements for addressing PTSI in paramedic service organizations emerged from the analysis: 1) recognition of non-traumatic and chronic stressors as precursors of PTSI; 2) skills and opportunities to build and maintain resiliency; 3) stigma reduction; 4) supervisor support; 5) programs, policies and practices for managing PTSI; 6) additional time for recovery; and 7) early and gradual return to work with modified duties. For each element identified through the interviews, we discuss the ideal scenario, along with the challenges of achieving that scenario. **Table 1 presents a summary of our results.**

Note that each identified element works in combination with others to create a system for the prevention and management of PTSI, and that the system may not function optimally if elements are implemented in siloed or stand-alone form. In other words, each element identified is necessary but is insufficient on its own to create an effective PTSI disability prevention management system.

Table 1: Summary of Findings

Identified Core Elements of WDM for Paramedics PTSI	Current Initiatives Available	Gaps/Barriers/Challenges	Recommendations
<b>1. Recognition of Stressors</b>  Ideally includes: <ul style="list-style-type: none"><li>- Chronic and cumulative exposures to trauma and suffering</li><li>- Self-identified critical calls</li></ul>	<ul style="list-style-type: none"><li>- A critical incident (as defined by the organization or the supervisor) will trigger mental health supports</li><li>- Critical incidents can be pre-defined by the organization</li><li>- Mechanisms for paramedics to report self-identified critical incidents are available</li></ul>	<ul style="list-style-type: none"><li>- No system to track paramedics' exposures to various calls and their triggers</li><li>- 'Criticalness' of an incident is different for everyone</li><li>- Many paramedics do not know their own triggers until they are triggered</li><li>- Some PTSI develop slowly over time</li></ul>	<ul style="list-style-type: none"><li>- Have a system to monitor exposures to critical events (both organizationally recognized and self-identified) to leave a record</li><li>- Formalize a system to ensure follow-up with self-identified critical incidents</li></ul>
<b>2. Skills and Opportunities to Build and Maintain Resiliency</b>  Ideally, allows for: <ul style="list-style-type: none"><li>- Meal during the shift</li><li>- Rest and recovery (sleep)</li><li>- Physical activity</li></ul>	<ul style="list-style-type: none"><li>- Health promotion and wellness committees</li><li>- Discounted fitness club memberships</li><li>- Mandatory Training (R2MR)</li></ul>	<ul style="list-style-type: none"><li>- Nature of the work is shift work</li><li>- Nature of the work is on-call (out the door within minutes)</li><li>- Limited time for rest breaks in high volume areas</li><li>- Understaffing</li><li>- Limited training on healthy coping strategies and strategies for managing work-life balance</li></ul>	<ul style="list-style-type: none"><li>- Provide a sufficient number of staff per shift to allow time for breaks, self-care, and defusing.</li><li>- Training specific coping strategies, management of shift work, work-life balance, and chronic and cumulative stressors.</li></ul>
<b>3. Stigma Reduction</b>  Ideally, an organizational culture that recognizes: <ul style="list-style-type: none"><li>- PTSI as an injury and not something to 'push past'</li><li>- PTSI as a normal outcome of exposure(s) to trauma, not weakness or incompetence</li><li>- Seeking mental health professionals is normal for the prevention and management of PTSI</li></ul>	<ul style="list-style-type: none"><li>- Mandatory Training (R2MR)</li><li>- Presumptive legislation for PTSD</li><li>- Discourages stigmatizing comments</li><li>- Encouragement for using and reminders of the available mental health services</li></ul>	<ul style="list-style-type: none"><li>- Resistance to change</li><li>- Nature of the work requires resiliency</li><li>- Training squeezed into orientation → limited attention of focus</li></ul>	<ul style="list-style-type: none"><li>- Continue to provide mental health training</li><li>- Discourage stigmatizing comments</li><li>- Provide mental health support services, encourage and follow-up with its usage</li></ul>

Identified Core Elements of WDM for Paramedics PTSI	Current Initiatives Available	Gaps/Barriers/Challenges	Recommendations
<b>4. Supervisor Support</b>  Ideally, support is: <ul style="list-style-type: none"><li>- Consistent</li><li>- Judgement free</li><li>- Followed up</li></ul>	<ul style="list-style-type: none"><li>- Supervisors initiated support programs/services after a critical incident</li><li>- Leadership training in R2MR</li><li>- Monitor baseline behaviours of staff</li></ul>	<ul style="list-style-type: none"><li>- High variability of supervisors</li><li>- Limited follow-up after a self-identified critical event</li><li>- Questions the criticalness of self-identified events</li><li>- Does not always grant time to defuse</li><li>- Put PTSI management responsibilities onto paramedics</li></ul>	<ul style="list-style-type: none"><li>- Have formalized policies and procedures stating supervisors' roles and responsibilities for the prevention and management of PTSI;</li><li>- Provide training for all supervisors on the<ul style="list-style-type: none"><li>o Disability management policies and procedures specific to PTSI</li><li>o Mental health first aid and other resources that are consistent with the training received by paramedics</li></ul></li></ul>

Identified Core Elements of WDM for Paramedics PTSI	Current Initiatives Available	Gaps/Barriers/Challenges	Recommendations
<b>5. Programs, Policies and Practices for Managing PTSI</b>  Ideally, various supports are available and accessible to accommodate individual differences	<p><b>Time to defuse</b></p> <ul style="list-style-type: none"><li>- Stress leave (1 hr - rest of shift off)</li></ul> <p><b>Support from Colleagues</b></p> <ul style="list-style-type: none"><li>- Partners</li><li>- Peer supporters</li><li>- Supervisors</li></ul> <p><b>Mental Health Professionals</b></p> <ul style="list-style-type: none"><li>- 24/7 distress lines</li><li>- E(F)AP (first few session free)</li><li>- (In-house) mental health professionals</li></ul> <p><b>Financial Supports</b></p> <ul style="list-style-type: none"><li>- Extended Health Plan</li></ul>	<p><b>Potential Consequences to Others</b></p> <ul style="list-style-type: none"><li>- High call volumes to attend to</li><li>- Did not want to transfer the workload to other colleagues</li></ul> <p><b>Potential Consequences to Self</b></p> <ul style="list-style-type: none"><li>- Confusion with the level of personal information that can be shared with regards to patients and fellow paramedics</li><li>- Fear that shared information will reach management</li><li>- Fear of losing livelihood security, credibility, and identity</li></ul> <p><b>Affordability</b></p> <ul style="list-style-type: none"><li>- Limited coverage for professional mental health services</li><li>- Contract workers may not qualify for employee benefits</li></ul> <p><b>Lack of Experience Working with Paramedics</b></p> <ul style="list-style-type: none"><li>- Limited mental health professionals that specialized in first responders</li><li>- Fear of traumatizing the listener</li><li>- Difficulty explaining work stressors</li></ul> <p><b>Negative Past Experiences</b></p> <ul style="list-style-type: none"><li>- Poor peer review or personal experience prevented future usage</li><li>- Limited follow-up after service use</li></ul>	<p><b>Reduce Consequences to Others</b></p> <ul style="list-style-type: none"><li>- Provide a sufficient number of staff per shift to allow time for breaks, self-care, and defusing.</li></ul> <p><b>Reduce Consequences to Self</b></p> <ul style="list-style-type: none"><li>- Training and awareness on what is considered confidential, case studies and examples provided</li><li>- Expand presumptive legislation to other mental illness (i.e., depressive &amp; anxiety disorder)</li><li>- Reduce the stigma of PTSI</li></ul> <p><b>Affordability</b></p> <ul style="list-style-type: none"><li>- Provide extended coverage that meets the health needs of paramedic staff, including psychiatric services</li></ul> <p><b>Educate Mental Health Providers</b></p> <ul style="list-style-type: none"><li>- Provide <i>train the trainer</i> programs for local mental health professionals</li></ul> <p><b>Reduce Negative Experiences</b></p> <ul style="list-style-type: none"><li>- If aware of service usage, follow-up with paramedics' experiences</li><li>- Share success stories on a bulletin or in meetings</li><li>- Complete formal program evaluations</li></ul> <p><b>6. Additional Time for Recovery</b></p> <ul style="list-style-type: none"><li>- Expand presumptive legislation to other mental illness (i.e., depressive &amp; anxiety disorder)</li><li>- Establish a check-in schedule between employee and employer</li></ul>
<b>6. Additional Time for Recovery</b>  Ideally, time and livelihood security provided during recovery	<p><b>Workers' Compensation</b></p> <ul style="list-style-type: none"><li>- Wage replacement</li><li>- Medical treatment</li></ul> <p><b>Employee Benefits</b></p> <ul style="list-style-type: none"><li>- Sick days/ vacations days</li><li>- Short term Disability</li><li>- Long-term Disability</li></ul>	<ul style="list-style-type: none"><li>- Dependent on diagnosis from medical professional<ul style="list-style-type: none"><li>o May not always get onto workers' compensation</li></ul></li><li>- Fear of being forgotten and replaced</li><li>- Contract workers may not qualify for employee benefits</li></ul>	
<b>7. Early and Gradual Return to Work with Modified Duties</b>  Ideally, paramedics have opportunities to gradually return to work as a paramedic or perform	<p><b>Gradual Return to Work Options Included:</b></p> <ul style="list-style-type: none"><li>- 3<sup>rd</sup> in car</li><li>- Reduced hours</li><li>- Reduced shifts</li><li>- Choice of partner/mentorship program</li></ul>	<ul style="list-style-type: none"><li>- Difficult to return to the place of trauma</li><li>- Not much work available</li><li>- Does not find administrative work to be meaningful</li></ul>	<ul style="list-style-type: none"><li>- Allow workers to gradually increase workload with consultation from medical professional</li><li>- Consider if the alternative duties were meaningful to the paramedic</li></ul>

Identified Core Elements of WDM for Paramedics PTSI	Current Initiatives Available	Gaps/Barriers/Challenges	Recommendations
meaningful alternative duties with continuous follow-up	<ul style="list-style-type: none"><li>- Avoiding peak times</li></ul> <p><b>Alternative Work Options Included:</b></p> <ul style="list-style-type: none"><li>- Administrative duties</li><li>- Community outreach/ public safety awareness programs</li><li>- Side projects at the organization</li></ul>		<ul style="list-style-type: none"><li>- Provide continuous follow-up during the RTW process</li></ul>



## Recognizing Non-traumatic and Chronic Stressors as Precursors to PTSD

The conventional belief is that PTSD is the result of a single critical incident. This belief has resulted in a lack of awareness that 'non-critical' incidents can also contribute to the development of PTSD. Interviewees, including paramedics, managers, and union representatives, emphasized the need to shift the misunderstanding of PTSD as attributable to a single critical incident to the realization that non-traumatic and chronic stressors are important contributors to PTSD. Consequently, paramedics with these conditions require timely treatment in order to prevent them from escalating to PTSD. Paramedic\_01 summarized this need:

*... just to say again, it's not always about that one call... Most medics, they don't suffer from PTSD or PTSD from one pinpoint traumatic incident... It could be other issues like people being overworked and doing a nonsense call after a stressful call, or like dealing with angry public... a lot of the media shows it like it's always this [one] event that caused this PTSD, but it's not always...it's a broad range of things that builds up and builds up and builds up and builds up that cause these symptoms.*

The majority of interviewees assert that risk/causal factors for developing PTSD, other than single events, should be recognized, including cumulative and chronic exposures to other people's suffering and trauma and exposures to relatable calls that are non-critical.

**Cumulative and chronic exposure to other people's suffering and trauma:** Paramedics are frequently and intimately exposed to suffering and trauma within the community. Even when not tending to an event, waiting and hearing the sirens throughout a shift creates a stressful environment, as explained by Manager\_02:

*There's an underlying tone of stress just being in that position of waiting for the tones to go off. This is kind of an important note to capture. So you can come in and do a 12 hour shift at one of our quieter divisions. Perhaps never turn a wheel, but for that entire [shift], you're on call not knowing what the next set of tones is going to bring. So, there's an underlying stress all the time that resides there.*

Layered on top of anticipations for trauma are the intimate exposures to situations where people are in crisis. Paramedics often deal with emotional and traumatic situations with family and community involvement. Compared to other first responder occupations, paramedics have prolonged intimate exposures with their calls as Paramedic\_03 explained:

*You may go into somebody's house, their personal residence, do a cardiac arrest and then in the same house, provide death notification to the family and then help to deal with the grieving family all within the scope of the same call. Whereas the other two major first responder organizations don't necessarily have that scope of intimate connection. They might have to tell somebody who's dead, but they didn't do the CPR on the person. For example, if you go to a horrific car accident, let's say, and the paramedics take the patient to the hospital. Well, for the police and fire department, their contact ended when we left, but our contact continues right through at the transport and to the hospital.*

In addition, paramedics sometimes feel unappreciated, wasting their time and not making a difference when they repeatedly serve the same person for the same reason, usually in mental health and substance use cases. Manager\_01 and Manager\_03 presented the scenarios and how these stressors could also lead to a PTSD:

*We have an increase in mental health and substance abuse calls. And those types of calls are creating unique stress for paramedics now too because... they often feel like they're going back to the same person, not making any difference in their lives. And, and those cycles keep repeating for the patients...So they feel like they're not doing anything or not making a difference and they're frustrated, and it's taken chunks out of them.... And again, paramedics, the people who get into paramedics, a lot of people are doing it because they've wanted to help and they want to make a difference. And when they feel like they're not able to do that, then that's a unique stress that's new. I've actually been witnessing it in the last couple of years more so than ever before.*

Manager 01

*And there are certain times of the day or certain times of the year where calls related to substance abuse are very prevalent and people will get worn out by those sometimes because you know, they see the same person day after day and it's kind of like, they just feel like they're wasting your time. And, and you know, because people don't appreciate the support that they're getting.*

Manager 02

Though not always traumatic, the frequent and repeated exposures to various traumas can reduce paramedics' capacity to cope with more significant, traumatic stressors.

**Calls that paramedics relate to:** Specific to personal experiences, there are some calls that a paramedic relates to, or empathizes with, more so than others. These calls are considered self-identified critical incidents and are often not recognized as traumatic unless the paramedic reports them as such. Manager\_01 provided examples of what may make a call 'critical' to a specific paramedic:

*Whether they go to a call with a person that's from their same life circumstance and that trips some triggers for them... Those can trigger different people. People who have been in similar circumstances. I have a wide range of people and, if you have a paramedic who comes from a family where there was alcohol abuse and violence in their own household, and they're in the middle of that call, that's a trigger for them and it goes well beyond that "trauma" call that everybody expects is going to be the one that's causing the harm to the paramedic, but there's all these other triggers that seem smaller to us that are big for the paramedic.... It's defined differently for each person.*

Paramedic\_03 echoed the need to recognize incidents that may be critical to an individual but not to others:

*The number one thing that you need would be organizational recognition that it was a critical incident to you. So is a critical incident to me may not be the same for you.*



Currently, some organizations provide a pre-defined list of “critical incidents” to dispatchers to notify the supervisor or the peer support team to check-in with those who have been exposed. However, other important stressors are often missed if not reported. Manager\_01 reiterated the need to acknowledge all types of stressors and mental health conditions associated with paramedic work, rather than solely focusing on the management of PTSD and critical incidents:

*I think we have to profess oversimplifying what’s happening with our staff, saying everything is PTSD. There has been this move towards calling everything that our staff go through PTSD or critical incident stress. And I think when we look at it that way, we are going to be missing the boat on quite a few things because depression, anxiety, and what we were talking about earlier with that futility piece, it’s going to get missed. And, I’m a believer that PTSD is overdiagnosed, and incorrectly diagnosed. And I say that at the risk of sounding politically incorrect. I know I do, but the reason I say it is because take for instance, a person suffering from PTSD or a person suffering from depression, PTSD and depression treatments are absolutely the opposite. And if we get them confused, we’re going to hurt people instead of helping people. So, I really think we’ve got to move away from PTSD everything...if we can move away from that PTSD and we’re looking at a more global picture of mental health and how that impacts our staff, and I think we’re going to be answering the needs of people more efficiently.*

**Summary:** In addition to the “big calls,” the following should be recognized as potential exposures that could lead to PTSI: Cumulative and chronic non-critical calls, the prolonged intimate exposures to emotional and traumatic situations with family and community involvement, the anticipation of waiting for call, and self-identified critical incidents. The identification of these stressors often stressors (i.e., stigma reduction);

- organizational mechanisms for reporting, monitoring and following-up with paramedics who have had a series of stressful incidents or self-identified critical incidents to create a record of exposures; and
- training for paramedics on the significance of having a record, and how to identify and report stressors that otherwise would not be captured by the organization.

## Building and Maintaining Resilience

Paramedic service organizations often promote healthy behaviours through wellness initiatives (i.e., sleep, nutrition, exercise and work-life balance programs). However, interview respondents noted that there were many organizational and occupational barriers that limited their application. Paramedics noted the need for opportunities to tend to basic self-care during their shifts. UnionRep\_02 described how small opportunities, such as having time to use the washroom and eating a healthy meal during a shift, can make a significant difference to one’s resiliency:

*...I think that, in terms of any resilience training, they state nice things, but they’re not putting money where their mouth is... and ensuring that we have time to eat while we’re at work. Like eat back at the base where we prepare a proper meal, all these things, alone, none of them sound like they’re huge for resiliency, but all put together, they absolutely are.*

Paramedic\_01 described the frustration of doing calls non-stop without having a chance to eat, especially when the calls were not urgent:

*Like you just feel so burnt out sometimes, like you haven’t had a break all day, you’d be going back to back to back. You haven’t had time to even eat and then you, you’re still doing like these silly things that are not what you sign up for. Like what your vision of an ambulance call should be... And you go there, you get people that are so entitled that you just feel so angry.*

Paramedic\_04 described some of the challenges that they’ve encountered in trying to tend to person care needs during a 96-hour shift:

*... what I find is we have no chance. We have no downtime in our 96 hours. Even if we’re not busy, the radio is still on... I can’t go for a walk. It’s impossible because we have to be able to respond within minutes. So, if it’s a beautiful day out, I can’t [go out for a] walk. I can go inside the, we have a walking track in our communiplex. I can go in there and walk around and around and around, but I can’t go out and enjoy the outdoors to go for an actual walk. If I go to the gym, I frequently get called out. I tried yoga and I was asked to leave because my radio kept going off during yoga classes and interrupting... Most people go to work, do their job, they get that break that they can be with their families and friends or do whatever they want, and then the next day go back to work again. We don’t have that option at all. It’s just 96 hours straight... We sleep when we can and I actually have a really, really hard time sleeping. I suffer from insomnia quite bad. I’ll go 24 hours or more without sleeping, and part of it is because I feel angry that my radio could go off [at] any moment and I’m not sleepy, but it’s hard. People ask how we sleep, we just try to sleep when we’re not on a call or on a transfer, and we try to do things like do our exercises and stuff where we’re not on a call or on a transfer, but we basically have broken sleep the whole tour. We’ll sleep for a couple hours and then we get a call and then sleep maybe for three or four more hours and get a call. And so, and then we’re expected that after a call, no matter what it is, we basically clean up our ambulances and put them back in service and then we’re supposed to be able to lay our heads down and sleep in case we get another call. So how do I sleep? Not very well.*

Paramedics were also hesitant to take breaks when they knew that other calls were waiting; and that if they took a break, the workload would get passed on to other team members. They saw it as selfish to take a break while others continued to work. This created a moral dilemma of wanting to be a team player while knowing that it was unhealthy to continue to work.

**Coping Strategies:** In addition to health promotion, paramedics are often mandated to complete the Road to Mental Readiness (R2MR), a basic mental health training course for first responders. As a component of the course, there are two modules, Healthy Coping Strategies and Mental Toughness, focused on providing “a set of evidenced-based, cognitive behavioural therapy-based techniques that help individuals cope with stress and improve their mental health and resiliency” (Mental Health Commission of Canada, 2018). The techniques include positive self-talk, visualization, tactical breathing, and SMART goal setting (also known as ‘The Big 4’). Although the course provided a foundation for mental health, many paramedics found the material to be too general and were uncertain of how it could apply to them. UnionRep\_02 emphasized the need for more discussion surrounding how to cope:



*I know that going through the R2MR and discussing coping mechanisms for instance, it would've been great if that was the focus of the day of training, discussing coping mechanisms, healthy ones and what other people are doing. I think there is an opportunity that was lost there. I think that there is too much focus on the textbook definition of this and that, and not enough focus on how we're gonna move forward and be healthy and actually cope.*

Other paramedics stressed that coping strategies should be individualized, and that the strategies they found most helpful and applicable came from their psychologist:

*Well a course is great, but it's so generalized because it doesn't apply to you yourself. I would love to be able to get people to have somebody they could work with to have somebody who knows them... just to get that personalized touch. Cause that's really what I fall back on myself, [it] isn't really the courses that you take and stuff. It's what you've learned over the years that works for you.*

Paramedic\_02

*... in the sense of, do I use the tools that I got from the continuing education, I mean they are in the back of my mind, I remember what they talked about, but it's not like I actively choose those tools that I fall back to, but a psychologist gave me the tools. I think those more useful, more relatable for me.*

Paramedic\_01

The underlying barriers to self-care were attributable to shiftwork and understaffing. The unfavorable sleep patterns decreased coping capacity, and the high call volumes and low staffing meant paramedics had very little time for self-care. Manager\_02 explained:

*The shiftwork component can lead to some decreased capacity, physical capacity, mental capacity in regard to adapting to the demands of the job.*

Resilience building and taking preventative actions to avoid PTSD is not a common way of thinking in the paramedic culture. When asked about organizational preventative initiatives, what was often mentioned was peer support, Critical Incident Stress Management (CISM), and employee assistance programs (EAP). It appears to be a common belief that PTSD cannot be prevented or avoided, it can only be managed. Manager\_01 shared their thoughts on prevention:

*The other things that we have in place in terms of mental health are more the reactionary pieces, the after the incident pieces, uh, my brains turning here a bit...You know, it's funny, in this business we're trained to deal with certain situations where we're not trained to prevent. So, it's really a change of headspace that we have to really get into and to really look at these preventative and different methods and making sure that health and wellness are taken care of all the time, not just when something happens.*

**Summary:** Exposures to traumatic events are unavoidable, but having opportunities to take a break, eat a meal during a shift and use the washroom, process calls, and have the time for appropriate coping strategies would help paramedics be more resilient and better cope with stressors in order to remain in a healthy mental state. Paramedic organizations should provide:

- Sufficient staffing to match typical call volumes in order to allow time for breaks, self-care, and to diffuse between calls; and
- Training specific to coping strategies, management of shift work, work-life balance and management of non-critical stressors.

## Stigma Reduction

Paramedics needed an organizational culture where disclosing a PTSD and seeking support would not be stigmatized. Three themes emerged to creating a work environment/culture that is conducive of self-reporting. Ideally, the organization:

- Recognizes that mental health challenges, such as PTSD, are legitimate health conditions, and are not something that can just be 'pushed past,' or 'sucked up.'
- Recognizes that PTSD, is a normal outcome from being exposed to traumatic events, and that PTSD is not a form of weakness, but a result of occupation exposure(s).
- Recognizes that, like going to a medical doctor for a physical checkup or to deal with a physical condition is normal, going to see a mental health professional for a mental health checkup or to address a mental health issue is also normal.

The following discusses how organizational recognition of the above-listed PTSD conceptualizations would improve the early reporting and intervention of PTSD.

**PTSD is an injury, not something to 'push past':** When a paramedic discloses a PTSD, they may be seeking support, validation, or making others aware of a potential concern or limitation. Discounting and downplaying individuals' PTSD, by not taking it seriously, saying that it's 'in their heads,' and that it is something that can be 'set aside' or 'push past', is a culture that has prevented paramedics from coming forward about their mental health. The fear of not being taken seriously leads to underreporting of mental health challenges. Examples are provided in the following quotes:

*There still are unfortunately, people who don't take this as seriously or, for whom mental health stuff is still kind of something to be ignored or pushed past or seen as a weakness. Those people still exist within the company and I would hate to think of somebody in crisis opening up to one of them, and not getting help, and then kind of shutting off and not engaging with the systems that we have.*

Paramedic\_02

*I think that people are still afraid to reach out and ask for those things or ask for help because they're scared of the stigma and scared of not even taken seriously.*

Paramedic\_04

With the mandatory mental health training (R2MR) and public stigma reduction initiatives, this stigma behind mental health has significantly decreased. Some organizations have taken additional strides to ensure that all reports of mental health challenges or PTSD are taken seriously and that supports are offered, as described by manager\_01 and manager\_02:

*...We still do have some of the old, push it down, suck it up and, and move on attitudes that are out there that we have to kind of fight through to make sure that we're limiting those types of responses.*

Manager\_01

*Early recognition and intervention and, the capability to feel comfortable coming forward. I think that's another stride we've made is ensuring all are/ will be taken seriously coming forward until that, we reduce that stigma that might be attached to mental health issues.*

Manager\_01



Taking PTSI disclosures seriously are vital to recognizing the individual differences of PTSI triggers and responses. It provides the opportunity to self-report incidents that go beyond the list of critical incidents pre-defined by the organization, including the cumulative and chronic stressors mentioned above.

When dialog about mental health challenges are taken as seriously as physical one, paramedics may have less reservations to talk about their own mental health challenges.

**PTSI is a result of work, not personal weakness:** Despite acknowledging that paramedic work places paramedics at risk for PTSI and that PTSI was a normal response to trauma, many paramedics had difficulties overcoming the stigma and/or self-stigma that PTSI was a sign of weakness and/or incompetence for the occupation. They often believed that it was their own inability to withstand, cope, and manage the stressors of the job as signs of being unfit for the job; often comparing themselves to other colleagues who have been exposed to the same or similar stressors and have been working for years without a PTSI. It was agreed that paramedic work requires mental toughness and resiliency, and so those who develop a PTSI may be viewed as weaker than their peers. Paramedic\_04 described the stigmas that their colleague felt during a mental health leave:

*When you talk about stigma, she had to start with some huge issues of embarrassment that she had to take this leave, and she basically cut ties with all of us... And it was because of the stigma of being on a mental health leave that she didn't want to talk to us because she thought we were all judging her... I think in my friend's case, and in probably other paramedics cases. So, you look at all your coworkers around... So we all work a core flex (96-hour shifts). Why can we do it, and not you? We all have seen death of children and multi vehicle collisions, multi casual incidents. Why can we take it and not you?... I think most people that I know and that have or have talked about taking mental health leaves are more worried about what their coworkers will think of them.*

In addition, there are current organizational discussions surrounding the potential implementation of pre-hiring screens for PTSI. Manager\_02 explained the discussions surrounding a pre-hiring screen and the challenges to address PTSI:

*An unknown at this time is how far is the pendulum allowed to swing. I mean, you know, the profession you're getting into, you know what you're most likely going to come across. When we've had this discussion about levels before, when are certain individuals simply not suited to the job?... Well, there has to be some recognition at some point. If you're an overly empathetic person or you bring work home with you every shift, you're not probably gonna survive too long in the profession. We are empathys by virtue of the fact that we're here to help people. However, there is a line that we're still trying to, because it's a way individualistic, it's hard to draw a line in the sand as to whether or not you're suited to the profession or not. We've had several cases where we really have to question whether an individual is suited to the job, not because of their lack of clinical skills or lack of directional sense or lack of bedside manner, but lack of being able to cope after the fact.*

Being perceived as unsuitable for the job and losing their identity as a paramedic has also prevented paramedics from reporting their PTSI. The most significant change to reducing this stigma within the past 10 years has been the presumptive legislation for PTSD in first responders, as demonstrated in the following quotes:

*I'm coming up on 30 years in the field. I can attest that this is certainly the biggest, the most impactful change to our industry that I have seen. Um, it's not call volume. It's not equipment. It's not educational requirements for the job. Single biggest change I've seen in my time has been the presumptive legislation and the recognition of traumatic mental stress in this field and open discussions about that.*

Manager\_02

*You know, nationally now that they've recognized that people who work in frontline responders, first response, fire, EMS and police. They recognize now that if they are asking for assistance based on this aspect... they don't have to build this huge case and spend a lot of time out because that's one of the things that we had that's been identified as being a real stressor and causing more stress is to have to convince somebody that you're needing support. So, it's deemed as an automatic thing... I think it's going to go a long way to helping people certainly reduce the stigma.*

Manager\_03

Interviewees agreed that more paramedics have spoken up in their organizations about their PTSI since the passing of the pre-sumptive legislation. However, despite the significant recognition of PTSD as a work-related injury, other forms of PTSI may still require evidence of its work-relatedness. UnionRep\_02 explained:

*Well, ones where you have a buddy self-identifying a mental health issue and they are diagnosed with depression or they're diagnosed with anxiety or they're are diagnosed with both, or they're diagnosed with some form of compassionate fatigue, all of these things. They don't trigger that DSM-V diagnosis and therefore the presumptive legislation does not cover them and they're stuck trying to piece together their exposures, and there is a culture of underreporting exposures. Because the presumption that what happened with the workplace, it's just not there for those injuries.*

Interviewees consistently suggested organizations need to manage mental injuries like physical injuries, and that mental health initiatives need be integrated into the health and safety system, as opposed to a separate initiative. Paramedic\_03 explained:

*... one of the problems that's arisen in my workplace is that maybe viewing the implementation of the CSA standard for paramedic mental health somehow differently than the normal health and safety stuff in the workplace. So, it's creating some conflict between the traditional and legally mandated health and safety committee. And another committee that's invented just to do the CSA standard, right? They're both workplace injuries.*

Often, PTSI initiatives is seen as an area that require subject matter expertise and does not fall into the traditional scope of health and safety teams. When PTSI is viewed as a work-related injury that needs to be reported rather than a personal issue, more paramedics may have less hesitation to report a PTSI.

**Normalization of seeking help for PTSI:** Utilization of mental health support should be normalized in order to decrease its stigma and increase its accessibility. Currently, there is an underlying stigma that people who use mental health supports are crazy, unstable, and/or mentally ill. Some paramedics had a fear of being perceived and/or treated differently if their colleagues had found out they were receiving mental health support. Manager\_05 shared their friend's reluctance to seek formal mental health counselling:

*And at the end of that phone call, the other person on the other end of the line had said to her, "you know, I want to encourage you to keep talking, but I need to let you know that if you call a third time that I have to put pen to paper and it has to go on the record that you've sought to help in this way." ... So, she felt that if she went with that third phone call that when it went on the record, the company would know that she was crazy... those were her exact words. And like, no, I don't think that's the way it works, I think you remain some anonymity in the process. But I said, "why would they think you're crazy? You're seeking help, like if you broke a bone, you'd go seek help. Like this is no different," but just still under that impression. She followed that up with to say, "Well, maybe short term, they don't think I'm crazy, but they might treat me different."*



For other paramedics, seeking mental health support meant admitting that something was wrong. Some had difficulties accepting that there was a problem; while others, perhaps because of the PTSD, may not even be able to self-recognize the problem. Paramedic\_01 described their first experience talking to a psychologist:

*It's hard to say there's something wrong with you. Yeah, It's difficult. But once you do acknowledge that, you can approach someone and talk about it. If you talk to the right person, then yeah, it's there for you to [provide the] help that you need...Like for me, at first, I was actually pretty nervous to go speak to a psychologist because of the stigma behind it. And you're like, "Oh, I want to talk to someone about my mental health and have to open up about it." Like I wasn't really down for it. And it took me a while before I actually opened up to him and he realizes that too. Like being able to talk about your feelings and how you're feeling is difficult... and there are a lot of medics that there are very Type A and we think we're very strong. Like we're physically able and we sign up for this job... so being able to admit that something is wrong, mentally, is difficult.*

Ideally, mental health supports are used as preventative measures to monitor and maintain mental health as oppose to a service that is used reactively when there is a problem. Paramedic\_01, and others shared their view of the need to move the utilization of psychologically services more upstream:

*The stigma before it's like "oh talking to a psychologist, Uh, it's kind of weird when you like thinking about your mental health," but the way I look at it now and I tell my colleagues it's actually good to check-in with the psychologist. So having built that rapport when you don't have any issue so that when you do have an issue, like you have someone that you already feel comfortable speaking with...It's like having a family doctor like just to check in with once in a while. It's important.*

Paramedic\_02 reiterated the difficulties with self-recognition of PTSD and the importance of having early exposure to mental health services:

*I can see people floundering around because if you've never had that background in it and you've never had to engage with mental health and you've never had to really think about it, I mean, it can creep up on you and people don't just kind of put it off and put it off and don't recognize it. And then by the time they do it, they're pretty far in the hole, really.*

Currently, organizations are investing more into mental health services and encouraging its usage. The encouragement helps to ensure that all staff are aware of the available services and demonstrate management's commitment to preventing and managing PTSD. It also helps to normalize service utilization. Thus far, word of mouth has been the most impactful method to reducing the stigma of utilizing mental health support. When colleagues shared their positive interactions with a mental health service, other members were more likely to give the service a try. One organization was able to breakdown the stigma of using their EAP through word of mouth:

*So, we have one woman on with our EAP who is great. She isn't taking on clients outside of us anymore because we're pretty much keeping her business up and one other company that she's on EAP for, and just through word of mouth, I mean, people know if they go through the EAP to ask for [name of counsellor]. She is wonderful, and so you get a few free sessions with her and she can help kind of navigate the system for you as well cause she's gone through it with so many of us, and I find that's probably where people are the most open about talking. So, if they've had their own struggles, it's not a secret when you go, like, people don't keep it secret that they've seen [name of counsellor]. If somebody's struggling, they say, "Oh, I've seen [name of counsellor] and she's great." And I mean there's no shame or stigma around that, which is great. Cause at the beginning, uh, years ago, I remember it, that wasn't the way that it was. People would keep those things secret. But now everybody, you, I mean, you talk about going to go see [name of counsellor]. Everybody's like, "Oh yeah, she's great, I go see her all the time."*

Paramedic\_02

When paramedics felt that mental health service utilization was not only for persons with mental health problems but good practice for resilience building and self-care, paramedics were more incline to use the services for early detection and remaining in a healthy mental state.

**Summary:** Work culture surrounding PTSD is the summation of all organizational actions and inactions to address PTSD, and consequently, how staff perceive PTSD. Although still present, the stigmas of PTSD in paramedic service organizations have drastically decreased over the past decade. Organizations should continue to:

- Provide training and education on mental health
- Discourage stigmatizing comments
- Provide mental health support services, and encourage and follow-up with its usage



## Supervisor Support

Mental health support services can be initiated in multiple ways: after an organizationally defined critical incident, after a self-identified critical incident, after noticeable performance and behavioural changes, or self-initiated by a paramedic. Supervisors are critical for the prevention and management of PTSI because they have the authority to take paramedics off the system, grant requests for stress leaves (e.g., having the rest of the shift off or having a period to defuse), and initiate support services (e.g., formal debriefing, critical incident stress management, or peer support). Supervisors also provide support by checking-in and following-up with the paramedics and support services. The supervisor's role is significant to the work culture and, how valued and appreciated staff paramedics feel.

**After an organizationally defined critical incident:** Supervisors are generally very supportive and ensure that mental health support services are readily accessible after an incident that the organization, the commander, or the deputy chief has defined as critical.

**After a self-identified critical incident:** However, when events are self-identified as critical there is greater variability in whether the paramedic receives the needed mental health support. Paramedic\_01 commented on the varying levels of support between supervisors:

*If you have a good supervisor, then you know, they can sell it pretty well and they can sell it to the duty officer and then they can probably do it. But if poor supervisor would be like, "Oh, why do you need an hour for this?"*

Some paramedics even found the inconsistency and unpredictability between supervisors in response to requests for mental health support to be very stressful, in and of itself:

*We have some supervisors that are very good, don't get me wrong, but we have some that are very bad and it depends which supervisor you get when you phone, we don't know who the supervisor is until we phoned and we need them cause they're not in our office... They're a couple hours away. When basically when certain supervisors answered the phone, my stress level just goes through the roof knowing I'm going to be talking to them and I might as well hang up the phone cause nothing's gonna happen.*

Paramedic \_04

The large variation in responses was also noted by managers, and attributed it to a lack of standardized training and policies. Manager\_02 and Manager\_03 emphasized the need for training and formal procedures to ensure consistency amongst the supervisory group:

*I think in our supervisor group there could be some tightening up of our training. There's inconsistency there and how supervisors are responding. But I think we need to focus a little bit more on the knowledge there and making sure that the practices are well known.*

Manager\_02

*...[be]cause some people are just better at things than others. And you know, if somebody has their opinion about how something should run, but you have a program that's specific, then they're obligated to follow the program regardless of how they feel about it...you sometimes deal with, like you have really experienced managers and then you have managers that are fairly new to the organization and they may not have received the training yet, but then all of a sudden they're confronted with an issue where they need to deal with a situation like this. So, it's important that they deal with it in a manner that's consistent with the program... [be]cause inconsistencies also lead to disjointed solutions.*

Manager\_03

In addition to the lack of standardized training, policies and procedures, other constraints can lead to detrimental decisions from supervisors that undermine support, such as understaffing, mandates to prioritize response times, or personal beliefs that the paramedic can push pass the PTSI. Paramedic\_01 explained their perception of how response times are prioritized over their mental health:

*Like some of the older management staff are saying, "You don't need to stop. Like you're fine." And calls to them are more important than staff and mental health... For upper management, like calls need to be done, like calls need to be responded by this time, like that's more important than their employees' mental health. So those are the culture that needs to be changed.*

Another reason why supervisors may deny requests for support after a self-identified critical incident is the fear of being taken advantage of. Paramedic\_04 explained:

*A lot of comments I get from supervisors is, well a lot of staff members try to pull the wool over supervisor's eyes and say, well this was a critical incident and, and basically all that person wants is the next day off cause they're going to do something. Whether that's true or not, I don't know.*

While there are supervisors who have reservations about providing support or granting stress leaves, there are also some that prioritize their staff's health and safety. Consistent with this notion, Manager\_01 described their approach to providing support:

*I make it my practice to check-in with people after calls that I'm aware of. And it's really tough to figure that out on what impacts who. So, it certainly leaves a lot of different calls out there. So, I do my best... and definitely if they've contacted me, I'm going to follow-up with them. There's no issue about that. That becomes a priority. It's always been a priority for me as a supervisor that my paramedic safety and health is the number one thing. Everything else gets dropped around it.*

**Proactive wellness checks:** Though not essential, some supervisors take it upon themselves to get to know their staff in order to build rapport, monitor early signs of performance or behavioural changes, and maintain a two-way dialogue so that paramedics feel comfortable reporting a PTSI. This practice is particularly helpful for detecting PTSI that develops over time. Manager\_01 discussed their approach:

*Something that I've always done as a supervisor is that I've taken the time to get to know my staff and understand them as best possible so that I can notice when they're reacting differently or strongly to something. And maybe even if they're not noticing it themselves or paying attention to it themselves... I do have part of my regular routine is to have touch points with the people and to speak with them. It's just a normal conversation. It doesn't even have to be connected to a call just to see if there's anything going on that I may need to pay attention to... then there's also the stuff that sort of crops up slowly over time. You start seeing those different things. So, you know, if I see somebody who's doing things that they wouldn't normally do, maybe they're more short tempered, they're lacking patience, or they're complaining about a lot of things. If I identify those things and I want to start talking about those issues with them and seeing if there's anything going on that runs a little deeper than a simple frustration...*

Other respondents had similar practices of checking-in with a paramedic to monitor behavioural changes and identifying potential cases of PTSI. Manager\_02 stated:

*And it's often that change in behaviour of the medic that flags us to try to understand what's initiating the change. And in many circumstances, it turns out that there was something that they have been withholding... withholding their concern about a call that they attended. And that's when, again, once we're able to trigger the response, the floodgates tend to open.*



The practice of proactively checking-in with staff members not only helps identify potential PTSD in its early stages but also maintains an open dialogue to facilitate early reporting. Paramedics also emphasized the importance of proactive check-ins for building a good rapport, as stated by Paramedic\_04:

*And so why would you reach out to somebody that has no interest in you. They never reach out to us to see how we're doing; we always have to reach out to them.*

Not all paramedics appreciated the check-ins or offers for mental health support. Some viewed it as a sign of weakness. This re-emphasizes the importance of stigma reduction and the need for culture change around the use of mental health supports. Manager\_05 explained why some managers may take a more passive approach:

*They almost take it as an insult that somebody is checking up on them and they see it as, you know, they're saying they're weak.*

Proactive check-ins are good practice but not standard practice for many supervisors. Supervisors had mentioned that they felt inadequately trained on the soft skills required to effectively provide mental health first aid. Rather, they often relied on other services such as the EAP, peer support, or CISM.

**Follow-ups:** After a paramedic has reported an incident or utilized a mental health support service (of which the supervisor is aware), there needs to be a follow-up with the paramedic to ensure the mental health supports are functioning as intended. Additional supports can be offered as necessary. Follow-ups help ensure that paramedics do not feel forgotten. Paramedic\_04 describes how a stress leave may not be effective without a follow-up to see if additional supports are needed:

*If you're not going to follow up with that employee and, and see if they need any actual mental health leave with a psychologist or... They basically, it's just dropped you, you're never contacted again.*

Instead of actively following up, some organizations encourage paramedics to provide feedback about a program. Manager\_03 described:

*We stress that if anybody ever has a questionable experience with this number, let us know what it is and then we can follow up with the organization, determine if it was just a personality thing with the other end of the call or if there's something more going on... So, we try to make sure that if people have a negative experience, we can resolve it. And that hopefully, with one another, they will talk about it and find out about it that way... I think one of the most important thing is that the medics talk with each other and they reach out to somebody who's had a positive experience and they can discuss what was positive. And then any person having a negative experience can say, well, I'll give that a try or, you know, that didn't work for me, maybe I should get more help. So, if we try to keep people communicating with each other and talking with each other, I think that's the most important thing.*

Without follow-up, paramedics have less of an incentive to report an incident because nothing will result from it if follow-up is not standard practice. Paramedic\_03 explained how follow-ups could promote early reporting of exposures and stressors:

*...having a more robust follow-up program on reported incidents so that people actually feel that when they do report something, somebody's paying attention to it. So instead of just reporting it and not being the end of it, you know, have some type of follow-up.*

**Summary:** Support from supervisors via proactive check-ins, follow-ups, granting of access to stress leaves, and coordinating mental health service providers are critical for motivating paramedics to access mental health supports on a timely basis, i.e., during the early stages of PTSD development, and facilitate remaining/returning to a healthy mental state. The organizations should:

- Have formal policies and procedures that include a description of supervisory roles and responsibilities in the prevention and management of PTSD; and
- Provide training to all supervisors on disability management specific to PTSD, mental health first aid, and other approaches that are consistent with the training received by paramedics.

## Programs, Policies and Practices for Managing PTSD

Multiple techniques need to be used by supervisors to match paramedics' diverse coping strategies. Paramedic\_01 described the variations in how paramedics coped after an incident:

The key forms of support that paramedics would like to see provided by their organization are time to defuse, support from colleagues (e.g., partners, peers and supervisors), and access to professional mental health services (e.g., EAP, mental health professionals, formal debriefing). From our interviews, paramedics had access to most of these supports, but their accessibility and efficacy varied across organizations. Other, less common, support services that some paramedics noted were therapy animals, chaplains, and programs that included loved ones.

This section highlights the current practices and barriers to accessing programs of support.

### Time to Defuse

Paramedics stressed the importance of having time to diffuse after a difficult call before going on another call. Downtime was needed for either collecting their thoughts, debriefing with their partner(s), using the washroom, having a snack or a (non-alcoholic) beverage. This defusal period could range from 15 minutes to taking the rest of the shift off. To be removed from the dispatch system for a defusal period, supervisor approval is often required (BCEHS was an exception). The time to defuse is not always accessible, often due to understaffing, high call volumes, and the moral dilemma described above. Paramedic\_01 summarized the accessibility and the use of the defusal period:

*It's that downtime to be able to debrief with your colleagues and chat with them. Sometimes we just don't have that ability, they're (the supervisors) like, "Okay, go back out there and do another call..." I feel like just having that ability to just rest immediately and think about the call, even just like have a drink, sorry not a drink as in alcoholic, just have a coffee, like sit down and just chat with your colleagues a little bit makes a big difference, huge difference... Sometimes they are not granted, they're harder for us to get because there's not enough staff.*

Managers that were interviewed also saw the value in providing time to recoup as an early intervention to avoid PTSD and remain at a healthy mental state, as reemphasized by Manager\_02:

*I want to provide immediate time for them to rebound and stuff [be]cause that whole thought of going and doing the next call when they haven't had time to decompress, that's a huge, huge thing. Even if they're just given an hour or two after a call that's impacted them. Sometimes they're ready to go back without any impact afterwards.*

There has been a shift in work culture to allow time for paramedics to defuse. Paramedic\_02 talked about the changes that they had noticed over the years.

*Management is offering to let people get out of the system now more than they did before. They're helping to get people's shifts off if the debriefing happens at the time when they're going to be working too, so they are sort of starting to prioritize it a bit more than maybe before.*

Although there has been a shift for some services, there are still services that are more reserved to authorizing adequate time to defuse. Paramedic\_04 shared their experience when they needed a stress leave (i.e., taking the remainder of the shift off) after a self-identified critical incident:

*We were called to a nine echo, which is no pulse and respiration. And it happened to be what I discovered when I got there, it was my friend that I've known since I was six years old and we're still really close and he was gone. We did CPR and everything, but he never made it. So, I phoned my supervisor when I got back from the call and he told me I could have an hour to clean myself up and get back together. Yeah. I, well, I just said some naughty things and shut off my radio and laughed, and I thought if I get disciplined later, I'll get disciplined. But I never heard anything else about it. I never got apology or that it was a bad thing to do or anything. I didn't get anything.*

In terms of early intervention, simply having time to process could prevent the build-up of stressors over time.

## Support from Colleagues (Partners and Peer Support)

Colleagues in the workplace have the ability to either mitigate or aggravate the impacts of PTSD and traumatic calls. In this section, we discuss how partners and peer supporters can support one another. The supervisor roles in supporting were discussed above.

**Partners:** Paramedics and their partners informally act as the first ‘line of defense’ in mitigating the impacts of PTSD. Interviewees all shared that having a compatible partner made a big difference for mental health. Generally, interviewees felt that most of their colleagues had the skills, knowledge, and ability to provide mental health first aid, with the exception of a few. Paramedic\_01 explained the value of supportive partners:

*After the call, the two of you sit in the ambulance and just being able to talk about it makes a hell of a difference. Just to be able to agree with each other or acknowledge the fact that we did something right, or what we did was everything we could have done. Like that already makes a big difference.*

Partners share a unique camaraderie of having experienced similar issues together. In many circumstances, the development of a PTSD stops at being able to speak with someone who also just lived through the situation and understands. They can clear the air and get things off their chest without needing to try to explain the situation to another person. However, finding the right partner can be a challenge. Manager\_03 summarized the difficulties of matching partners at their organization and the impacts of incompatible partners:

*...like some people have extremely good working relationships with their partners and that, that helps them a lot to go to work every day because they know they have the support. And then other times, you know, people have a working relationship and the person who they feel trapped with. So, you know, in a remote community where you only have a few people working together after a while, their only alternative is to leave the job because they don't feel supported by the partner. You know, we sometimes aren't able to move people around in such a manner can eliminate them having to work together. So that also relates to or that also creates stress in the job. And even in Whitehorse, sometimes you get people that work together that have a personality conflict. Um, having a large workforce, you know, we have the luxury of being able to move people from one shift to another where they don't necessarily have to work with each other. We try to discourage that kind of thing because it's, you know, we wanted people to engage in the programs and then be able to work together. But sometimes it comes down to moving people around. But in the communities where you're dealing with a very, very small crew, then you know, the, the, um, the relationships sometimes become fairly critical in a person being able to perform self-confidently and not feel stressed.*

An imbalance in responsibilities between pairs of paramedics created an additional stressor for the lead paramedic. For example, paramedics had negative emotions when paired with partners were ‘new or green’ or at a lower level of qualifications. Paramedic\_02 explained the impacts of the added responsibilities to one paramedic:

*A lot of the people who have gone off because of the added stress of just always being responsible for these calls or even little calls, just always having to take on all the responsibility is just that they wish that they had for the serious calls. They wish they had another ACP that they could bounce ideas off of so that they didn't feel so alone. So that all the responsibility didn't fall onto them.*

Arranging for compatible partners that support one another in their shared experiences was vital to defusing the impact of traumatic events and for the early detection of any behavioural and performance changes.

**Peer support:** More formally, peer supporters are available for paramedics to speak with about mental health challenges. Peer supporters are also frontline paramedics who have received additional training to provide mental health support. Examples of additional training include Applied Suicided Intervention Skills Training, Mental Health First Aid, and critical incident stress management. Peer supporters are also aware of other mental health support services and can encourage paramedics to use these services for further assistance. They can also encourage and assist paramedics in submitting incident reports to create a paper trail. Peer supporters tend to be easier to talk to because there is no power dynamic, as seen in supervisor-to-paramedic interactions. In fact, managers often relied on peer supporters to provide mental support to the paramedics. Paramedic\_01 summarized the peer support program below:

*Within our service, we have something called a PRT, so peer resource teams. So, they're medics, nominated by medics, like nominated by us to become trained to help special frustrations. They're phone calls. Just call them up and they can have chats with you, um, talk to you or they can provide you with the necessary help that you need so those guys are probably even better at providing [mental health] first aid than us.*

The peer support program can be initiated, often after a critical call, by the individual, the dispatcher, or the supervisor. Manager\_02 summarized the multiple ways the peer support program can be activated.

*... either someone approaches the peer support team directly or our command group is trained to recognize when peer supports should be called into play. And let's take the example of a mass casualty incident in the community... Our commander triggers our peer support team to respond to the medics involved in that circumstance. They receive training to be able to identify what types of circumstances should be moved forward. It can be at a specific request of this, of the paramedic running to call, but it doesn't need to be, we can also trigger the peer support team to reach out if you haven't, if that individual hasn't come forward, we reach out regardless.*

Peer supports were often seen as the starting point for many paramedics to engage with the mental health system.

## Mental Health Professionals (In-house Psychologists/ EAP Counsellors)

Some paramedics preferred or needed support from mental health professionals. Organizations have started to invest in providing more access to mental health professionals, either through the E(F)AP counsellors, mental health referral networks, or in-house mental health professionals. Paramedics who have used the services have found them generally helpful. Paramedic\_02 shared the value of what an in-house mental health professional may bring to the prevention and management of PTSD:

*I think we need, I would love to see us get a mental health professional on staff. And I know that's probably a bit of a pipe dream cause it's expensive and there's a lack of resources all across the province anyways and Canada, not just our problem. But if we had somebody and if people had to go in and check-in and had somebody right there, who could do, cause I mean mostly my own coping strategies came from my own struggles with mental health when I was little and going through, um, like with my own psychologist and psychiatrist and a therapist and going and getting my own personalized coping strategies so that now I recognize these things in myself and I can easily do the things that I know work for me.*

However, there are other challenges of having in-house mental health professionals, such as confidentiality concerns, that will be discussed in the next section.

## Barriers to Accessible Programs and Services

Despite the provision of multiple mental health initiatives, and the multiple mechanisms to engage with it, there were barriers, in addition to stigma and supervisor authorization, that prevented paramedics from engaging with them. UnionRep\_01 described the challenge in making mental health services more accessible:



*The struggle we have is creating a system where we say you can do something but we make the system accessible for you to do it.*

In addition to stigma and requiring management authorization, five core considerations emerged as to why paramedics chose or chose not to use mental health services. The elements involved in paramedics’ decision making included potential consequences to themselves and the service, affordability, whether the mental health service would understand what their going through, and reviews from their peers.

### Potential Consequences to Others

Paramedics face a moral dilemma on whether or not to access services such as time to defuse or stress leaves. Although they may want to take time off, they fear its impact on service operations and what others may think. UnionRep\_01 described the thought process:

*At the end of the day, that is a moral dilemma for our workforce that, if I don’t go back to work, the call volumes are gonna be impressed upon others. You know, and from my perspective, and I worked in some of the busiest stations in the lower mainland for many, many years. You can only do one call at a time. So, I do about a call an hour. That’s how long it takes... And if somebody goes away and a car goes down, you really can’t impact me much more than that because right now the call volumes are such, as soon as I clear, I got another call...So there’s still a lot of people that really feel that it’s a disservice to take that time and not show up. It shows weakness because now all of a sudden everybody else is picking up the slack even though it isn’t always the case.*

Many organizations provide options for taking a stress leave, sick day, and disability leave; however, the fear of letting their organization down and making others pick up the slack are often barriers for requesting time off.

### Potential Consequences to Self

In addition to acknowledging potential consequences to the service, paramedics considered the potential consequences to their reputation and livelihood security. They considered how information shared with a partner or mental health service may adversely impact their earning potential, and consequently, their family’s livelihood.

**Confidentiality:** To improve the accessibility of mental health supports, there should be mechanisms in place to provide reassurances and to ensure confidentiality. Manager\_01 emphasized the importance of confidentiality for paramedics.

*The stuff that’s safe for them to talk about in the write up room, they don’t care if people know, but man, if they’re struggling and they’ve got some, maybe they’re treading into some substance abuse problems or they’re having some other difficulties with their relationships that they don’t want others to know about. Yeah. They’re, they want the confidentiality.*

All mental health services ensure confidentiality. The information is protected under the Health Information Privacy Act. However, there is still hesitancy in using mental health services, especially services such as the EAP, and in engaging with mental health professionals that have an association with the employer. Some paramedics believe that there is a potential conflict of interest because the services are refereed or contracted by the organization. An earlier quote (in the normalization of service usage) described a woman stopping her usage of the EAP because she was afraid that her company would find out, despite the known confidentiality agreements. In another example of substance use, Manager\_05 provided a scenario of the potential complications that may occur in handling health information when the service provider knows the employer:

*So, if you’ve got an employee that you know struggling with substance use disorder for example, and the clinician’s concerned about them and now they call the employer and say, “Hey, I got a problem so and so is not going to work. This person, I’m sure that you sent me that I’m treating, but they really, they really need treatment.” Well now that person’s breached confidentiality of that patient and now what does the employer do with that information?*

Further, because the psychologist is in-house, full confidentiality may be limited as peers and supervisors may see who is entering the mental health professional’s office, so some people prefer EAPs.

*So we have the peer support team, we have the staff psychologist, we have the employee assistance program, um, which offers, um, which offers services as well to, um, some of our staff prefer to go that route because it’s more anonymous.*

Organizations take confidentiality very seriously and ensure that only the necessary information is shared; however, the fear of personal information being shared has been a barrier for the engagement of mental health services, especially if there are downstream consequences to livelihood security.

**Livelihood security:** Paramedics were reluctant to report a PTSL or seek support when there were consequences to their livelihood. UnionRep\_02 provided an example in Ontario where reporting a mental illness may result in losing both their identity and ability to work as a paramedic.

*I think the whole thing falls apart when you have a paramedic who self-identifies with a mental health concern and then they suffer any kind of retribution for that, whether it’s perceived retribution or otherwise. If they suffer loss of income, if they can’t make ends meet all of a sudden, then you’ve lost before you even got started. Cause that person trying to do the right thing and when they’ve been now lost in the void of bureaucracy and paperwork, and just bad experiences... So for instance, your F class driver’s license and you come forward and you indicate that you have mental health concerns and you see the doctor and then your doctor gets your very standard form with a bunch of checkboxes that ask you if you’ve ever had a heart attack or a seizure atrial fibrillation. One of the checkboxes is mental health so then they say, you’ve come to see me for mental health, there’s checkbox there and then all the sudden your license is suspended and you can’t work as a paramedic.*

Consequences for casual workers are even more evident as Paramedic\_04 mentions:

*Casual employees are scared not getting shifts anymore, so they don’t speak out at all.*

Further, when paramedics were unsure whether their injuries would be approved by workers’ compensation, they tended to try to push through and continue to work with a PTSL. Paramedic\_01 explained:

*But like for you to take more off. You always have to think in the back of your mind like am I actually going to get paid for it because WSIB could be decline these. It’s not like an actual physical injury, but like let’s say, I lifted somebody and I hurt my back. I know how WSIB is going to claim that claim because I have a physical injury, like they gonna let me be home and rest before I get better and come back on the road. But If I do a bad call and I need to take a week off. It’s a harder sell... That’s not easy. Like so people are hesitant to like take some time off and recoup after a bad call because you might not get paid for it. WSIB can like decline you very easily.*

If deemed eligible for workers’ compensation or short-term disability, recipients do not suffer from losses in wage (medical costs covered in the next section); however, fear of potential financial or job loss has been another barrier to engaging with mental health supports.

### Affordability

Paramedics needed access to services that were affordable, ideally free or covered by the extended health plan. Due to the high costs of psychological services, if the coverage was inadequate, mental health professionals would only be engaged reactively when a serious problem occurs, rather than proactively with monitoring and prevention. Paramedic\_01 explained the barrier:

*I guess that’s one of the barriers, you’re asking barriers and I guess now that I think about as like barriers would be like how expensive it is, but now that we have some of it covered, I mean like my psychologist will charge at \$250 a session. \$250 like that, like the fee \$3,500 can get you 10 sessions a year. For me to come back to work, I saw him probably like 20 something times plus, that was covered by WSIB so it’s easier for me at that point. if somebody doesn’t have that kind of coverage, I’m not gonna go see somebody at \$250 an hour, you know?*

Aforementioned, workers’ compensation does not cover all mental illnesses, particularly the ones caused by the accumulation of exposures. If deemed ineligible for workers’ compensation, medical expenses would need to be covered by the benefits plan, which often may not be sufficient for treatment. Without a sufficient benefit plan for psychological services or qualifications for workers’ compensation, mental health professional were inaccessible. However, organizations offered many other programs and services that are free, such as EAP (for the first few sessions) and peer support. Paramedic service organizations would also promote distress lines that are available 24/7.

**Experience Working with Paramedics**

Paramedics preferred mental health supports that were knowledgeable in the unique stressors of paramedic work. Paramedic\_01, 03, and 04 discussed their challenges and barriers of sharing their experiences with someone who was unfamiliar with paramedic work:

*It’s hard to explain it to somebody when they haven’t gone through like the entitlement people, like the nonsense calls as well as those stressful calls... even me explaining it to you...I have that sense of are you really going to understand like what I say.*

Paramedic\_01

*We’ve had people go to the EAP and the counselors have burst out crying and said they couldn’t hear anymore and couldn’t deal with it. So EAP is, has not been successful in emergency services simply because it’s not designed for the type of trauma that is experienced.... Generally, the EAP programs, they just don’t have the background to deal with the type of trauma, psychological trauma we’re talking about here.*

Paramedic\_03

*They couldn’t understand EMS... I spent most of the time explaining to that person what core flex... I felt, I hadn’t got any help from them...*

Paramedic\_04

Conversely, paramedics were more inclined to share their PTSI challenges with people who they knew would ‘understand.’ Paramedic\_01 shared the benefits of having an in-house mental health psychologist who understood their work:

*Within our service there’s a clinical psychologist that I spoke to once or twice and she’s nice, she’s cool, she’s relatable, she understands what we do and what kind of stress we get.*

Additionally, Manager\_03 explained why paramedics were less reserved to approach them because of their shared experiences:

*I’ve worked with them on the streets and you know, I’ve developed a fairly significant level of trust between them, so they don’t have any resistance to come to me and talk to me. They know that I understand and have experienced the same thing they have. So that’s a big help. I think it’s having management also aware of the issues on the street. And like I say, I worked the, in the trenches with them, so they trust me.*

Organizations have found it difficult to find mental health supports that were also knowledgeable in paramedic work. Manager\_02 discussed:

*One of the challenges we’ve had in finding support is finding someone who understands the field, understands the profession.*

More ‘Train the Trainer’ programs are available to teach mental health supporters the stressors of paramedic work, and to create a referral of mental support who are knowledgeable in-service paramedics.

**Word of Mouth and Previous Experiences**

Observing or hearing from peers who have used the service was a significant factor for whether a paramedic chose to use the service or not. Positive experiences facilitated engagement, and negative experiences veered people away. UnionRep\_02 summarized how observations of negative experience reduced engagement:

*...people see that, that gets promoted in the community and then the next person is far less likely to self-identify.*

As another example, Paramedic\_02 shared how before the presumption legislation for PTSD, people didn’t bother to file a workers’ compensation claim because they heard of others getting denied. Applying for compensation felt pointless and out of reach:

*I would hear people say, Oh, I would try and do that, but everybody gets denied.*

Also, having had negative prior experiences would also stop paramedics from re-engaging with the support systems in place. Paramedic\_04 said that they would not bother reaching out to their supervisor for support after two negative experiences.

*...We’re suppose to call the supervisor and they are supposed to work with us after critical incident. The couple of times I’ve done that, I find it doesn’t help. They don’t support us. So, I don’t do that very often. Uh, basically my partner and myself, I’ve a wonderful partner. I love her and I never want her to leave between us too. We, we help each other out.*

Supervisors that were interviewed were aware of the need for paramedics to overcome the stigma behind seeking support and how negative experiences would greatly deter paramedics from reporting and engaging with the services. Some of the supervisors explained how they encouraged paramedics to report negative experiences, so they can make the changes to ensure more positive experiences. The demonstration of follow-up and management actions to support paramedics reduced barriers to accessing services (see Supervisor Support).

**Summary:** In many organizations, multiple PTSI prevention and management initiatives including, time to defuse, peer support, EAP, CISM, and other mental health professionals were available to paramedics; however, there were many factors that limited its utilization. In addition to overcoming stigma and supervisor authorization, the potential consequences to others and themselves, costly out-of-pocket fees, and negative experiences from peers, all inhibited engagement with the programs. The organizations should:

- Provide extended coverage that meets the health needs of paramedic staff
- Training and awareness as to what is considered confidential, provide case studies and examples of what is considered to be confidential
- Expand presumptive legislation to other mental illnesses (i.e., depressive & anxiety disorders)
- Reduce the stigma of PTSI
- If aware of usage, follow-up with paramedics’ experiences with service usage
- Share success stories on bulletins or in meetings.
- Provide train the trainer programs for local mental health professionals



## Additional Time for Recovery

For paramedics dealing with debilitating PTSD, additional time would be needed for recovery. To access additional time to recover, paramedics would need to present a medical note (completed by a medical professional) stating the length of time needed for recovery. Programs and policies that provide time for recovery included workers' compensation, sick days, and short-term/long-term disability leaves. The type of support provided during this time is dependent on medical assessment and the workers' compensation board, and is beyond the scope of this document. Regardless of the type of leave, there has been confusion regarding contacting the paramedic on leave.

Paramedics on leave wanted to be contacted by their supervisors for a non-work-related check-in on their health and well-being. Paramedics often felt forgotten and replaced when employer contact was limited. Paramedic\_02 summarized their observations:

*So, a lot of people feel like they just kind of, if you go off, you're just kind of forgotten about, tossed aside and replaced with somebody new, which isn't great. Also, a lot of the feedback... is that they feel forgotten by the company. So, you give all these years to them, and then you go off and you're struggling and the company doesn't check-in with you, doesn't acknowledge the good work that you've done, just kind of leaves you hanging. So, a lot of them never hear from management unless they need to engage with them. Unless management needs something from them, so that leaves people feeling a little hurt. And I feel like maybe management's ignoring people because they're afraid of bothering them during the time that they're off, but people want to know that they're respected and that they're cared about and that they're not just forgotten once they're out.*

From the employer's perspective, supervisors believed that checking-in may re-traumatize the person on leave as they do not want to be reminded of work. Consequently, management rarely checks-in with employees on leave, as described by Manager\_03:

*I think in my experience that's probably the most problematic. So, when they're off of work, you have to balance how much here you're trying to connect with a person so that you're not re-traumatizing them essentially. They identify you as being part of the problem because you belong to the organization that's caused the issue with them. So, we tried to move it off to the HR departments... is that the HR department can keep in communication with the members, so that there's a bit of a hands-off approach. HR is well aware of what the problem is, and they can communicate with them and they can build a relationship there so that we don't have to get directly involved in being, you know, being the party that's associated with their problems. And then, as, people move away from the organization for a little while, they tend to just ignore it all together. Cause sometimes that's the easiest way to deal with the problem is to ignore it. But sometimes we have to reach out and trying to touch bases with people to say, "Hey, you know, we're just checking in. How are you doing? It's time for you to let us know what you need from us and things like that." So, we've tried to reach back to them and some of them can take a little while to get in touch with them. And you're not sure, are they ignoring you or you know, is there really a problem still? So that, I think probably it's the most crucial time is when they're away from the work is trying to keep them engaged enough that whether they need more help or are getting the help that they need. That's the one thing we struggle with. And there again, it's privacy, right? Be, how much can we, how many people can we reach out to or how many people can we use as a resource to kind of try, get in touch with this person. That complicates it sometimes.*

In some cases, the workers' compensation board prohibited the employer from contacting an employee to protect the employee from being guilted back to work. Paramedic\_04 shared:

*So, they're [WCB] quite worried that [the PSO] will try to convince her to come back before she's ready. So, I don't know if this has happened in the past or what, but that's what her impression is, that they're [WCB] afraid that management will try to convince her to come back before she and WCB feel she's ready. And so, I think she's, she's afraid she'd be easily swayed by management to come back to work if they made her feel guilty.*

The issue of employee contact is an emerging topic of discussion, and one manager shared her/his idea of establishing a communication plan in the early stages of the medical leave. Manager\_01 stated:

*I think as long as we have a practice and then in that practice, we're responsive to whatever the paramedics feedback is. If they say, don't call me back, I'll contact you, then we have to respect that. But if somebody says, thank you, thank you for checking in on me, I'm doing the best I can or things are improving or things aren't going so good, but you know, and you can check in on me. So, I think there's a way we can figure this out too.*

**Summary:** Additional time to recover was necessary for some paramedics with debilitating PTSD. A medical note would be required to receive this time to recover. Increasing accessibility of mental health services through stigma reduction or even providing an in-house mental health professional may provide more opportunities to obtain a medical note. Ideally, wage replacement and medical expenses would be covered to help recovering paramedics maintain their livelihood. Expanding the presumptive legislation to other mental illnesses (i.e., depressive & anxiety disorder) can further address the issue but is beyond the scope of the study. During the recovery period, the employee and employer should establish a check-in schedule.

## Early and Gradual Return to Work with Modified Duties

When and if a paramedic has recovered from a PTSD and has been cleared to return to work, the paramedic may need accommodations to gradually re-integrate themselves back to the frontline or to alternative duties. This process is highly dependent on the functional assessment completed by the medical professional as described by Manager\_02:

*Well both physical and mental problems, we do provide accommodations for involvement depending on limitations [be]cause we don't go too far down the trail of being able to fully understand what the issue is, but we need to know what limitations we're being faced with so we can assign appropriate work... We rely heavily on the clinical evidence, and then we decide what's suitable based on those limitations*

We present potential work accommodations to re-integrate paramedics into the frontline while minimizing the risk of re-exacerbating their PTSD symptoms. Options for alternative duties are also provided.

**Gradual return to the frontline:** Returning paramedics often needed a gradual re-integration process through slowly increasing workloads. Some of the work arrangements for gradual return to work included:

- Working only day shifts
- Avoid peak times
- Be a third in the ambulance (less duty)
- Reduced hours
- Reduced shifts
- Mentoring programs (ability to select a partner they are compatible with)

A challenge with finding work accommodations for paramedics with a disability is ensuring confidentiality and preventing other colleagues from viewing it as a sign of favouritism or unfair treatment by the organization. To ensure that all staff understood the rationale for accommodations and to limit the feelings of unfairness, jealousy, and resentment, UnionRep\_02 suggested to include potential work accommodations into paramedics' basic training, they stated:

*At first that's not very well received by anybody; because as confidential as the matter is, when you see somebody who's all of a sudden who's placed onto a premium dayshift truck, people know something's up right? And so, one thing is in ensuring confidentiality, absolutely. One of the accommodations in place, but also preparing workers for the types of events, so they can wrap their minds around the fairness versus the disability need...so that there isn't those types of reactions when these things occurred. These perspectives of unfairness, once people realize, this could be me, this can be something that I need, people tend to be more accepting.*

Another challenge of returning to the frontline is the unavoidable traumatic events or triggers. The nature of paramedics has been to put their patients' needs before their own health, safety, and well-being. Manager\_02 explained this challenge:

*I mean it's very common on to paramedic group is that everyone will dive in, feet first to do what needs doing and then deal with the consequences later. We've even seen that some of our folks who are suffering PTSD injuries, PTSI injuries in the workplace on modified duties have been, um, called upon to provide patient care inadvertently, such as they're doing equipment swap [inaudible]. They come across a motor vehicle collision on the highway that's to stop and address it. And in every instance that we've seen, they have stopped, they have addressed that, they have treated and so forth. And then after, after everything calms down to them to sort out their challenges again.*

Catching up on missed training during the leave was another barrier to returning to the frontline. Standard operating procedures are constantly being updated in healthcare, and paramedics need to be current in their training to work in the field. Many paramedics on leave for PTSD/mental health do not return to the frontline and require retraining for other positions in the organization.

**Options for "meaningful" alternative work:** Prolonged medical leaves decrease the likelihood of RTW; and so, paramedics who are not (yet) able to return to the frontline could be offered alternative duties. The interviewees have specified that the alternative duties should be meaningful and accommodate the functional abilities of the individual. Readily available alternative duties were usually administrative tasks, which paramedics did not find meaningful. Manager\_01 explained:

*I think we can do better on ensuring that, um, the work that we're giving them is meaningful because sometimes they get a kind of put into these menial type of clerical tasks. And if you get inside the head of a paramedic, they do not want that type of task and don't find that meaningful at all.*

Paramedics also faced difficulties leaving the frontline and losing their identity. Manager\_03 explained:

*They lived most of their lives identified as a frontline responder and all of a sudden they're either retiring or you know, they've had an incident and now they're no longer able to identify as that. And that's very stressful to some people.*

Some paramedics try to ensure that they are not returning to alternative duties as they fear that they would be permanently transitioned out of the frontline. Manager\_04 expressed their experience of offering alternative duties to paramedics:

*So, when we offer meaningful work, that's generally what we're offering is, is those types of administrative modified duties. And people are not usually receptive to that. So, unfortunately instead of coming back to do modified duties, they'll just get their doctor to say no, they'll just be off for another month. So, most of our paramedics, when they're coming back from mental injury, they'll come back to the on-car portion, not many will return to their, the modified administrative duties.*

Two frontline members, who experienced the return-to-work process, believed that workers' compensation also shared this fear and have advised workers not to accept alternative duties, as described by Paramedic\_02:

*Workers' comp even told [him], cause he had offers to do some of that at first and they, they told them not to offer that. Um, because you may just end up, cause if they don't retrain you or they may not help you get retrained, you could just end up in that administrative job forever. So, their fear is that you've just ended up sliding into filing PCR's for the rest of your career. Um, which is not what people want. Right. They want to do something that feels worthwhile.*

Finding meaningful work for paramedics has been a challenge for many organizations. Some services have put paramedics on off-car projects or on public training and awareness programs.

Union representatives had two different beliefs about how early work modifications should be applied for a paramedic with PTSI. One believed that the organization should cover health care costs immediately (within 24 – 48 hours) and find any type of work modifications to re-integrate the worker as soon as possible in order to keep them a part of the team and organization. The belief is that paramedics will feel valued by the organization's prompt initiative to cover medical expenses and find alternative duties. UnionRep\_01 explained how their organization is currently implementing a stay-at-work approach for paramedics with physical injuries in the hopes of applying it to psychological injuries in the future:

*So, workers' comp brought in a system, it's called a stay at work program. The concept is if you're injured at work or even at home, come in, we're going to put you to work in the moment. We're not gonna wait. They had no idea how to do that for psychological injury. Even workers' comp didn't know how to put that together and what that would look like. But they're very good at physical injury. So, what we agreed to is we're going to start off with MSIs. We're going to start off with sprains and strains and we're going to develop a program where you get access to a physiotherapist within 24 or 48 hours. It doesn't matter if you're part time when, no benefits or full time or whether it happened at home or at work. We're going to get you in. We're going to get your modified duties that shift or the next shift to your back and keep your working. And the whole idea of that program is to develop the system because they want to do use it for a psychological injuries...And so what I just explained to you is, you know, that kind of cost savings rather than paying somebody sick time or wage loss and having your rates go up and stuff like that, by implementing and paying for the physio you've now just mitigated all those costs and then you've actually got a return on what you've been doing, the side effects, which most of them don't measure and don't understand until they get there is what we talked about earlier, value. Paramedic feels valued: My employer's looking after me, they care about maybe putting me to work right away. They're not leaving me alone. So that return to work program is mitigated, uh, immensely just being, feeling valued and staying at work. If employers could understand that part, that there's so much value in being a part of the group that they love to keep a work and you're going to get stuff out of that employee and you're going to get him back to work faster.*

Despite the benefits from the stay at work program for physical injuries, how it can be applied to PTSI are still unknown. UnionRep\_02 shared their fear that returning workers too soon to modified duties may take away from needed recovery time, especially if triggers are work-related:

*...They offer modified work to everyone, which becomes of great benefits to our part time workers who are wanting to secure income. It's not always of benefit to full-time workers who could be receiving short term disability benefits with full income outside of working... that could be what they need to mentally recover.*



Compared to physical injuries, stay at work programming may be challenging if the triggers for PTSD are work-related. Many services can provide immediate mental health supports for paramedics with PTSD through the EAP, peer support, or in-house mental health professionals.

**Summary:** Under human rights codes, the organization is mandated to provide work accommodations for workers with a disability to the point of undue hardship. Work accommodations for returning to and staying at work are highly dependent on the functional abilities prescribed by a medical professional. As such, the organization should:

- Ensure that alternative duties are meaningful to the paramedic with PTSD;
- Provide gradual workload increases; and
- Continuously follow-up throughout the process to ensure that accommodations are effective and not exacerbating symptoms.

## Conclusion

Through semi-structured interviews with key informants from the Canadian paramedic community, we identified seven core elements of an effective and accessible work disability management system for addressing PTSD: 1) recognizing non-traumatic and chronic stressors as precursors to PTSD; 2) build and maintain resiliency; 3) stigma reduction; 4) supervisor support; 5) programs, policies and practices for managing PTSD; 6) additional time for recovery; and 7) early and gradual return to work with modified duties. Each element is an important part of an effective disability management system for the prevention and management of PTSD, but insufficient on its own. Essentially, the seven elements all need to be part of a disability management system for the system to be robust and optimally effective. Recommendations from this study will be embedded in the *Canadian Work Disability Management System Standards for the Prevention and Management of PTSD in Paramedic Organizations*.



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## Appendix 1

# Interview Guide for Supervisors, Managers & Deputy Chiefs

### Definition of post-traumatic stress injury (PTSI):

As defined by Public Safety Canada, PTSI is “a non-clinical term that encompasses a range of mental health injuries, including some operational stress injuries, clinically diagnosed post-traumatic stress disorder (PTSD), anxiety, and depression. It characterizes symptoms as injuries caused to public safety personnel as a direct result of their work.”

### PTSI Hazards on the job

#### 1. Do you believe that paramedic work puts paramedics at risks for post-traumatic stress injuries?

*If yes...*

What about paramedic work puts paramedics at risk for PTSI?

*If no...*

Why not?

### Sense of competence in staff to address PTSI

#### 2. After a potentially critical incident, do you feel that you have been adequately trained to provide mental health support to your paramedics?

#### 3. What training have you received for addressing PTSI amongst your paramedic staff?

**Probes**

- Did you find the training helpful?
- How would you make it better?
- What do you think are the potential barriers that may prevent the implementation of these recommendations?

#### 4. This is a question about the culture of disclosing or reporting mental health concerns. Do paramedics typically come to you when there is a problem, or do you have ‘get it out of them’?

#### 5. As a manager, when would you like to know about a mental health concern or PTSI among your staff.

a) When do you think a paramedic should start to seek help?

#### 6. How confident do you feel about your paramedic staff providing support or psychological first aid to one another? What training have they received?



## Specifics of the current programs

**7. Does your organization have any policies, programs, or practices to help prevent PTSD or maintain good mental health amongst your paramedics?**

**Probes**

**Examples:** Training/education, social events, pre-employment screening, stigma reduction programs

- How could these policies, programs or practices be improved?
- Are there any barriers that have been preventing the implementation of these improvements?

**8. After a potentially critical incident, are there any policies, programs, or practices to identify and support paramedics who may be impacted by the incident?**

**Probes**

**Examples:** Defusing, Debriefing and Check-ins after a critical incident, peer support, stress leave, employee (and family) assistance programs, mental health referral network, in-house mental health professional, extended health plan

- How could these policies, programs or practices be improved?
- Are there any barriers that have been preventing the implementation of these improvements?

**9. How does your organization support a paramedic who is still working, but dealing with a PTSD? Are there any programs, policies, or practices available?**

**Probes**

**Examples:** Work modification/accommodation or Stay-at Work programs for paramedics with PTSD

- How could these policies, programs or practices be improved?
- Are there any barriers that have been preventing the implementation of these improvements?

**10. If a paramedic is suffering from PTSD and cannot work, walk me through the process of what the organization needs to do to return the paramedic back to work, from the reporting of the mental health injury, the leave of absence, coordinating the return to work, all the way to finding the right work accommodations.**

**Probes**

- Timeline vs. self-paced RTW

## Available resources to organization

**11. How does your organization develop these programs and policies that you had mentioned? Are there any third-party resources available?**

**Probes**

- Does your organization collaborate with third party programs in the community?

## Monitoring of current programs

**12. In your opinion, how readily accessible are these programs to the paramedics?**

**13. How do you ensure that disclosed information is confidential?**

**14. How do you measure the effectiveness of the programs?**

**Probes**

- Participation rates and attendance, sustained RTW

## Additional Comments

**15. Do you think a management framework for addressing PTSD in paramedic service organizations is necessary?**

**16. Is there anything else you believe is important for us to know in developing a standard for preventing and managing PTSD in paramedic service organizations?**

## Appendix 2

# Interview Guide for Paramedics

**Definition of post-traumatic stress injury (PTSI):** As defined by Public Safety Canada, PTSI is “a non-clinical term that encompasses a range of mental health injuries, including some operational stress injuries, clinically diagnosed post-traumatic stress disorder (PTSD), anxiety, and depression. It characterizes symptoms as injuries caused to public safety personnel as a direct result of their work.”

### PTSI Hazards on the job

#### 1. Do you believe that paramedic work places paramedics at risk for post-traumatic stress injuries?

**If yes...**

What about paramedic work puts paramedics at risk for PTSI?

**If no...**

Why not?

### PTSI Training

#### 2. What training have you received for preventing or coping with PTSI, or for providing psychological first aid?

**Probes:**

- In paramedic college
- At your organization
- Other resources
- Did you find the training programs helpful?
- How would you make it better?

### Sense of control to address PTSI

#### 3. Do you feel competent in caring for yourself after a critical incident?

**Probe:**

What would make you feel more competent?

#### 4. Do you feel competent in providing support or psychological first aid to a colleague after a critical incident?

#### 5. In general, do you feel confident that your colleagues have the skills, knowledge and ability to provide support or psychological first aid for other colleagues?

### Current programs and program needs

#### 6. Does your organization have any initiatives to help prevent PTSI or maintain good mental health amongst their paramedics? These could be programs, policies or practices that aim to build awareness for mental health problems and their associated symptoms, build resilience to deal with PTSI, or reduce the stigma of PTSI.

**Probes**

- Examples: Training/education, health promotion, stigma reduction programs
- How would you make it better?

- What do you think are potential barriers that may prevent the implementation of these recommendations?

#### 7. After a potentially critical incident, what would you need in order to feel supported by the organization?

**Probes**

- Are there any programs, policies, or practices that your organization implements after a potentially critical incident?
- Examples: Defusing, Debriefing and Check-ins after a critical incident, peer support, stress leave, employee (and family) assistance programs
- How could these policies, programs or practices be improved to fulfil your needs?
- Are there any potential barriers that may prevent the implementation of these recommendations?

#### 8. What do paramedics need to feel comfortable enough to report their PTSI challenges?

**Probes**

- What policies, programs, or practices does your organization have in place to encourage the reporting of a PTSI?
- How could these policies, programs or practices be improved to make it easier to report mental health concerns?
- Are there any barriers that have been preventing the implementation of these improvements?
- At what point should a paramedic report mental health concerns to their supervisor or seek help?

#### 9. For paramedics who are working with a PTSI, what is needed to promote recovery and ensure that symptoms are not exacerbated?

**Probes**

- How does your organization support a paramedic who is still working, but dealing with a PTSI? Are there any programs, policies, or practices available?
- How could these policies, programs or practices be improved?
- Are there any barriers that may prevent the implementation of these recommendations?

#### 10. If a paramedic is suffering from PTSI and cannot work, walk me through the process of what this worker needs to do to return to work, from reporting the injury, filing for workers' compensation, getting treatment, to re-entering the workforce.

**Probes**

- What are the barriers and facilitators for recovery?
- Is there a timeline?

### Program Evaluation

#### 11. In your opinion, how accessible are these programs?

#### 12. How would you make suggestions to the organization about preventing or managing PTSI?

### Additional Comments

#### 13. Do you think a workplace framework for addressing PTSI is necessary?

#### 14. Is there anything else you believe is important for us to know in developing a standard for preventing and managing PTSI in paramedic service organizations?



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