

Making the Strong Stronger

An Investigation into how the Toronto Paramedic Services
Address Staff Operational Stress Injuries

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Executive Summary

The Ombudsman initiated this investigation on June 26, 2015, after receiving complaints from employees of the Toronto Paramedic Services (TPS). The complainants were disappointed with how they were dealt with when they experienced persistent psychological injuries arising from their work as paramedics and emergency medical dispatchers. Such injuries, known as Operational Stress Injuries (OSIs) included anxiety, depression, alcohol and drug dependency and post-traumatic stress disorder (PTSD).

On July 2, 2015, the Ombudsman publicly announced the investigation in order to encourage TPS employees to share their stories, and to assure them of the confidentiality of the Ombudsman's investigation process. This was necessary because of the stigma surrounding OSIs and mental health challenges among first responders, in particular, and society in general.

The Ombudsman received 123 complaints from paramedics and dispatchers. Investigators interviewed 139 people, including 40 paramedics and dispatchers, 57 additional TPS and City staff and 42 members of other first responder groups. In addition, the investigators conducted a substantial amount of comparative research and a literature review.

TPS has been a leader in providing psychological services for first responders. The Ombudsman's office heard multiple times that the service is leading the way in a field that has no road map.

It has had an in-house staff psychologist for 29 years, the only paramedic service in Canada to do so. The service also has a well-regarded Peer Resource Team (PRT), a group of TPS staff who are available to support colleagues in need.

Employees also have access to one or more of the City of Toronto's Employee Assistance Programs (EAP). These programs provide counsellors who assist employees with issues ranging from financial problems to depression. Many TPS paramedics and dispatchers felt the counsellors are of minimal benefit as they are unfamiliar with the specific stresses that they face on the job.

TPS employees can receive up to \$300 annually for psychological services. This is significantly less than other first responders in Toronto: members of Toronto Police Services are covered for up to \$3,500 annually for psychological services while Toronto's firefighters get \$1,000 annually.

Other services are also available, including workers' compensation, staff chaplains and up to two days of leave after a difficult call.

Paramedics and dispatchers told our investigators that while the stigma surrounding operational stress injuries is much less than in previous decades, many employees are still reluctant to ask for help because they are afraid of showing weakness. Witnesses reported that some in the service still felt they should "suck it up," that traumatic calls

were part of the job, and that employees should have known what they were signing up for when they chose this career.

Investigators were told of the cumulative impact of stress and that many medics and dispatchers try to carry on with their work without acknowledging the psychological injury that affects them. Then, when they face a tipping point, they can no longer cope. Dispatchers reported their own particular stigma about admitting to actually having an OSI, because they are not "physically present" at the incident and therefore were not expected to be affected by stressful calls.

Research shows that first responder organizations in some other jurisdictions are adopting innovative strategies to support the mental health of their employees. These include developing comprehensive psychological health and safety plans, voluntary annual mental-health check-ups, as well as pre-employment screening and training at the beginning of a career, so that first responders can better handle the difficult jobs they undertake.

The investigation found that TPS has in place the elements of a comprehensive psychological services program. However, those elements are insufficiently coordinated.

The role of the staff psychologist is not documented and unclear to some. The current psychologist has a number of duties, including short-term counselling, referrals, coordinating the PRT, responding 24/7 to critical incidents, and providing training and education to staff. Yet there is no strategy or framework on how to prioritize these functions.

The role and responsibilities of the PRT is not documented in policy. There is also no protocol setting out when and how the PRT or psychologist should be notified of stressful calls or incidents. The Ombudsman found that members of the PRT are not trained in suicide prevention and that the TPS does not have a formal suicide prevention and intervention strategy in place.

TPS is not immune from the societal stigma associated with mental illness. This stigma permeates most of our organizations and communities. In first responder, para-military and military institutions, the stigma is exponentially more pervasive because of the added "suck it up" attitude.

The reality of societal stigma around OSI, coupled with the challenging work of TPS paramedics and dispatchers, means the TPS has the responsibility to continue making improvements.

The Ombudsman made 26 recommendations, including nine related to improving the organizational structure for psychological services.

The balance of the recommendations address issues related to confidentiality, policy development, education and training, trends analysis, and pre-employment screening.

All of the recommendations were accepted and adopted by the City Manager and the TPS.

1.0 Investigation Process

1. On June 26, 2015, I notified the City Manager that I was commencing an investigation on my own initiative to examine how the Toronto Paramedic Services (TPS) addresses operational stress injuries¹ affecting its members.²
2. The investigation was initiated as a result of complaints brought to my office about the manner in which the TPS was handling operational stress injuries. The complaints raised systemic issues, including alleged inadequate supports and services for members that may be impacted by operational stress injuries and insufficient organizational training and awareness on the topic.
3. Given the nature of the allegations raised by the complainants, as well as issues of confidentiality associated with the investigation, I decided this would be a systemic investigation as opposed to one focused on the specific circumstances of a complaint. The focus was on what systems and supports, policies and procedures the TPS had in place to address operational stress injuries for paramedics and emergency medical dispatchers.
4. On July 2, 2015, I issued a news release announcing my investigation. This has not been a normal practice for my office. My reasoning for doing so was two-fold: to encourage members of the TPS to share their experiences, both positive and negative, to help us better understand how the TPS was handling member operational stress injuries and; to assure members of the TPS that our process was completely confidential.
5. My office received a total of 123 complaints and submissions from members of the TPS as part of this investigation. This included hearing from emergency medical dispatchers, paramedics, supervisory and civilian staff.
6. The investigation was assigned to a team, led by one investigator, with the assistance of four other investigators and two ombudsman representatives.
7. In total, the investigative team conducted 139 interviews, a record number of interviews completed by my office as part of a single investigation. This included 40 interviews with complainants and 57 interviews with TPS staff, both current and retired. Investigators also interviewed 42 stakeholders, including jurisdictions outside Ontario and beyond Canada.
8. Within the TPS, investigators interviewed the Chief, the four Deputy Chiefs, and the Commanders from each of the five operational districts. We also interviewed two previous Chiefs of TPS (formerly Toronto Emergency Medical Services), and

¹ As will be explained in more detail, operational stress injury is used as a non-medical term to describe any persistent psychological difficulties arising from activities performed in the line of duty, including anxiety, depression, alcohol and drug dependency, and post-traumatic stress disorder.

² This notice was pursuant to section 171(1) of the *City of Toronto Act, 2006* and sections 3-33 (c) and 3-35 (A) of the City of Toronto Municipal Code, Chapter 3.

a retired Deputy Chief. We interviewed every member of the TPS Peer Resource Team, as well as some former members of the team.

9. Investigators interviewed the current staff psychologist and the first staff psychologist hired by the service, dating back to 1986. We interviewed the Acting Commander of the Communications Centre, the Acting Commander of the Professional Standards Unit, the Commander of Education and Development and the Commander of Education and Quality Improvement for the Central Ambulance Communications Centre. We spoke with a sampling of Superintendents from each district, as well as some Deputy Commanders.
10. Outside the TPS, we interviewed staff at the City of Toronto's Employee Assistance Program and Occupational Health/Safety and Disability Management Section of Human Resources. We also spoke with a Deputy Chief at Toronto Fire Services and psychologists at the Toronto Police Services to learn how those services were addressing operational stress injury for their members.
11. We interviewed individuals from the provincial Ministry of Health and Long Term Care and Emergency Health Services Land/Air Division in order to understand what, if any, provincial involvement there was in this issue.³ This included speaking with the base hospital Medical Director for TPS.
12. We spoke with clinicians, psychiatrists and psychologists familiar with the issue of operational stress injury in the first responder context who have treated paramedics and emergency medical dispatchers for stress injuries. We spoke with academics and researchers that have focused on first responders, paramedics and operational stress injury. We also obtained information from the Ontario Psychological Association and the College of Psychologists of Ontario.
13. We spoke with representatives from the Toronto, Ontario and Canadian Paramedic Associations to hear their perspectives on the issue, as well as speaking with representatives from the Ontario Association of Paramedic Chiefs and the Paramedic Chiefs of Canada.
14. My investigators contacted other paramedic/emergency medical services within Ontario to learn about their approaches to addressing operational stress injury, including York Region, Superior North, Ottawa, Renfrew County, Durham Region, Essex-Windsor, Peterborough County/City and Frontenac County. Outside Ontario, we spoke with representatives from British Columbia, Alberta, New Brunswick and Saskatchewan. We also contacted international stakeholders, including the Fire Department of New York, the London Ambulance Service (U.K.), New South Wales Ambulance and Ambulance Victoria.

³ The Ontario Ministry of Health and Long Term Care provides funding for 50 percent of eligible expenditures incurred by the Toronto Paramedic Service for the provision of land ambulance services, and 100 percent for the Central Ambulance Communications Centre. (O. Reg. 129/99: Costs Associated With the Provision Of Land Ambulance Services under the *Ambulance Act*, R.S.O. 1990, c. A. 19.)

15. We obtained and reviewed documents from the TPS on issues related to our investigation, including emails, policies, memos, presentations and statistical reports. Investigators reviewed a substantial amount of research and external documents on the topic of operational stress injury and first responders.
16. We received excellent cooperation from the TPS throughout the course of the investigation.

1.1 Two out of three (psychologists) ain't bad

17. As noted above, my office spoke with two of the three staff psychologists that have been employed by the TPS.
18. Our lead investigator contacted the second staff psychologist that served with the TPS from 1992 to 2010 on two occasions requesting his participation. On both occasions the former staff psychologist declined, citing issues of 'confidentiality' as his reason. This was despite our clear and detailed explanations that we were not looking for confidential details relating to the interactions that he had with staff.
19. The powers granted to my office through s. 172 of the *City of Toronto Act* and s. 19 of the *Ombudsman Act* allow me to summon any person to speak as part of our investigation. Although the investigative team considered using this authority to issue a summons, ultimately the decision was made not to as we had sufficient information.

2.0 Operational Stress Injury – What is it?

20. Operational stress injury is a non-medical term that was coined by the Canadian Forces to describe any persistent psychological difficulties arising from activities performed in the line of duty, including anxiety, depression, alcohol and drug dependency, and post-traumatic stress disorder (PTSD). The term is not a diagnosis but rather a cultural characterization, intended to convey that the brain and mind, along with the body, can become injured.⁴
21. A 2014 briefing prepared for the Paramedic Chiefs of Canada defines operational stress injury as a "non-medical term used to describe psychological problems from mentally and/or emotionally traumatic circumstances."⁵ The briefing notes that the most well-known form of operational stress injury is PTSD. However, the briefing points out that responses to stresses in the workplace vary among individuals. It also notes that the concept of an operational stress injury allows

⁴ Ontario Ombudsman Andre Marin "In the Line of Duty: Investigation into how the Ontario Provincial Police and the Ministry of Community Safety and Correctional Services have addressed operational stress injuries affecting police officers." Ombudsman Ontario Report, October 2012, p. 14.

⁵ Ad-hoc Committee on Operational Stress Injury. *Operational Stress Injury in Paramedic Services: A Briefing to the Paramedic Chiefs of Canada*. Paramedic Chiefs of Canada, 2014. online: http://www.paramedicchiefs.ca/docs/bcs/PCC_Ad_hoc_Committee_on_Stress_Injury_Report.pdf.

for focus to be placed upon individuals who may not go on to develop PTSD but who still require assistance from their workplace to address operational stress.

22. Throughout this investigation, my office found that the use of the term operational stress injury allowed for members of TPS to share their experiences without concern about whether they had a formal diagnosis of PTSD. Indeed, many members that my staff spoke with did not have a formal diagnosis, but believed they have been impacted on an emotional level by stressful experiences as part of their work with the service.

2.1 Operational Stress Injury and TPS – Why the need for this investigation?

23. Over the past 15 years, there has been a growing awareness of the impact that working as a member of the military or first responder (police, fire services, paramedics) can have on mental and emotional health. Anecdotally, many of those that we spoke with attributed this growth in awareness to the efforts of retired Lieutenant-General Roméo Dallaire, who has spoken extensively about his struggles with PTSD.
24. Along with that growing awareness, there have been issues raised about how well the military and first responder organizations have done in addressing operational stress injuries amongst their members. Specifically, there have been systemic investigations conducted by the Department of National Defence/Canadian Forces Ombudsman (2002, 2003, 2008 and 2012) and the Office of the Ontario Ombudsman (2012) into how the Canadian Forces and the Ontario Provincial Police, respectively, have addressed the issue.
25. With regard to paramedic services and their handling of operational stress injuries, there has been a growing awareness and discourse, with some suggesting that PTSD is on the increase in some jurisdictions,⁶ and, more broadly, the lack of services/support available to paramedics for this issue.⁷
26. In fact, the 2014 report commissioned by the Paramedic Chiefs of Canada, the first of its kind in Canada, was in response to a demand for information about current knowledge and practices from some paramedic chiefs on how to address operational stress injuries.⁸ In our conversations with the past president of the Paramedic Chiefs of Canada, he said the idea behind commissioning the report was to shine a light on the issue of operational stress injury and start a dialogue on how it could be addressed.

⁶ *Ibid* at p. 7.

⁷ C. Drewitz-Chesney, "Post-traumatic stress disorder among paramedics: exploring a new solution with occupational health nurses using the Ottawa Charter as a framework" Workplace Health and Safety (June 2012) online: <http://www.ncbi.nlm.nih.gov/pubmed/22624848>.

⁸ Paramedic Chiefs of Canada briefing, *supra* note 5.

27. TPS is widely considered to be a leader amongst paramedic/emergency medical services in addressing operational stress injuries. Indeed, the service is the only one in Canada that has a full-time, in-house staff psychologist to assist members, a position that dates back to 1986. Notwithstanding, some of the preliminary complaints we received from members of the TPS suggested that perhaps the service was not achieving as much as it could, or should, to address operational stress injuries.
28. In keeping with the role and function of an ombudsman, my intention in launching this investigation was not to uncover evidence of the failure of TPS. Rather, it was to engage in a dispassionate assessment of the evidence and, where relevant, offer constructive recommendations for improvement to better address the needs of paramedics and emergency medical dispatchers impacted by operational stress injuries.

3.0 Perspectives from Paramedics and Emergency Medical Dispatchers

29. Although this investigation was systemic in nature, it was important to hear from individual paramedics and emergency medical dispatchers from the TPS about their experiences.
30. There were some that contacted us to share positive stories of how they believed the service helped them to deal with their operational stress injuries or otherwise assisted them during stressful periods in their lives.
31. One individual that we spoke with became so emotional when he recalled the tremendous support he received from the service that he had to excuse himself from the interview. Throughout this investigation, we heard the frequent great lengths that the service had gone to offer assistance to members.
32. Not everyone that contacted us felt that they had a positive experience.
33. As I suspected at the time of launching the investigation, confidentiality was indeed a significant concern. The perception amongst many was that they would be treated differently by their employer and their peers if it was discovered they were struggling with an operational stress injury. Some individuals chose to make their submissions anonymously.
34. Despite the best intentions of TPS, not the least of which is having a full-time staff psychologist, there are members who suffer in silence and struggle in their attempts to cope with operational stress injuries. Although we heard that the stigma attached to stress injuries within the service is nothing like it was 30 years ago, and that the "suck it up" mentality of yesterday is no longer tolerated, unfortunately that is not the reality on the ground for many of the members that contacted my office.

35. I have included in the report a sampling of the comments and experiences that my office received from those that felt let down or otherwise believed that the service could be doing more to address operational stress injuries. The information shared has been anonymized to protect confidentiality.
36. I have included these member experiences in order to provide a voice to the men and women that have been impacted by operational stress injuries but who are fearful of coming forward. I believe that sharing the views and experiences of those that are suffering silently serves to reinforce the importance of having effective policies and programs, services and supports in place to address the issue.

3.1 Stigma

37. There remains a serious societal stigma attached to the issue of mental health. TPS is not immune to that stigma. One of the main themes that we heard from members that contacted my office was that there remains a fear of admitting that you may need assistance.
38. The possibility of being viewed as "weak" or the "weak link" by peers or management, we were told, was something that prevented people from being open. "I'm afraid to be perceived as weak" one paramedic told us, "therefore, I'm afraid to ask for help." This was exacerbated by the fear that admitting to struggling emotionally could jeopardize career opportunities, or worse, prevent them from continuing as a paramedic or dispatcher.
39. Some felt there was a residue of the "suck it up" attitude that we were told was characteristic of the service decades ago. One seasoned paramedic who has been diagnosed with PTSD told us that the attitude among some of the supervisory staff is that paramedics "knew what they were getting into when they got here. If they can't handle it, they should leave."
40. We spoke with a paramedic who has been with the service for many years. This paramedic took a lot of pride in being able to handle whatever the job threw at him – until one call in particular overwhelmed his capacity to cope. Ever since then, the smell of blood has now become a trigger for him, to the point where he was not able to comfort his own child after the toddler sustained a split lip.
41. This paramedic told us that he would not seek assistance because the smell of blood is something that, as a paramedic, should not bother him. Recently, he was finding that his reactions are getting worse and he is worried that not doing anything is going to complicate his situation further. Paramedics, he felt, "don't admit weakness", because they are the ones that help others. This feeds into the "suck it up" attitude that he believes is perpetuated by some supervisors, especially when these same supervisors state that they have dealt with much worse and have got through it.

3.2 Suffering in Silence – "How are you doing?"

42. Many paramedics told us that typically it is not the circumstances of a traumatic call that is troublesome, rather it is the belief that they have not been offered support by the service after such calls.
43. One paramedic told us that after a difficult call, often what is needed is a contact from someone like a superintendent. Not receiving that offer of support is what bothers him the most. In fact, the desire to just be asked "how are you doing?" by someone in the service was shared by many paramedics that contacted my office.
44. One paramedic, who is also a member of the Peer Response Team, told my investigator that he would guess that "only a handful of times" over his career had he ever had a superintendent ask him if he was okay after a call. "And that's kind of huge. Just those few words, are you okay, is really, really big."
45. In accordance with the collective agreement, paramedics are "guaranteed" a minimum of one hour out-of-service following a difficult or critical call (as defined by the paramedic). Some paramedics felt this was not something that they could access because it was "frowned upon" by their superintendents.
46. This was particularly an issue amongst the younger paramedics. A new paramedic told us that he was afraid if he requested down time too often, then he would be disciplined. "As a result" he told us, "I often just 'work through it', push it down and get on with the next call." Another paramedic with only a few years experience, expressed fear that asking for help after responding to what she felt was a traumatic call would ultimately cost her her job. To make matters worse, her colleagues seemed to be taking what she felt was a difficult call in stride. She explained her predicament:

I was not asked if I needed time to compose myself and I was scared to ask for help...I felt the need to pretend that I was also unaffected. That is the mentality that is strong in our workplace. We are to brush aside our own emotions/needs and continue on, because there is always another call waiting.
47. There was a feeling expressed by many that they were expected to get on with the next call in the queue without taking any time to compose themselves or obtain support, even if that was just taking 20 minutes to clean-up and finish their notes.
48. A paramedic with only a few years experience expressed his frustration about his superintendent not asking how he and his partner were doing after pronouncing the death of a patient. This paramedic thought it should have been readily apparent to the superintendent that both paramedics were shaken by the

incident. "I never once...was offered any help or (asked) if I needed to talk to someone or needed time off," he told us. "I still struggle with this call and it has affected my sleep and will probably be something I carry with me my entire career."

49. As shared by a senior paramedic that had only recently been diagnosed with PTSD, paramedics are "expected to deal with a five year old death or a five-day old death. I'm expected to be OK with that...and we do that. We do it at a cost."

3.3 Cumulative Impact of Stress - Not just one call

50. For some, operational stress injury was not a product of a single call but developed over time, sometimes without them even knowing that something was wrong. We heard from members about the effects of an operational stress injury that could manifest itself in an increased use of sick days, attendance/performance issues, and, for some, reaching a breaking point.
51. One Advanced Care Paramedic shared with us the challenges he had in trying to understand what was happening to him, why he was feeling the way he was after being involved in a variety of traumatic calls and then why one call was giving him trouble:

I was all alone and I just didn't know what was happening. I wasn't sleeping because when I closed my eyes I started seeing the scene again, hearing the noises and just re-living it. So sleeping wasn't really an option, so then I'd start drinking to try to go to sleep. I knew something was wrong, but I didn't know what.

52. Another Advanced Care Paramedic with over a decade of experience said he forced himself to "tough it out" in order to stay on the road and do his job. But he struggled, using his sick time for days when he just could not handle it:

I would get severe anxiety going in to work. I would get serious calls dispatched to me and I would get very anxious, so the only thing I had to turn to, which was unfortunate, but I just started using my sick time. There would be days where I just couldn't go in because I just mentally couldn't do it.

It was a horrible time in my life – both at work and at home it affected me. I wasn't a fun person to be around. I almost lost my marriage because I was so down and felt so isolated...it truly affected me.

53. A theme that we heard from some was that, despite the struggles associated with operational stress, employees were able to succeed in their positions. Indeed, we spoke with some senior paramedics that had years of service but who

acknowledged that they believed they have been impacted by operational stress through an accumulation of experiences.

54. For some, the plan was to keep going, fearful that acknowledging they were dealing with their own operational stress injury would diminish their reputation in the eyes of their peers. "If people think that I've got my own issues" said one senior paramedic, "they're not going to come for me and I'm going to let them down."
55. For others, there were attempts to carry on without acknowledging that they may need support. This was not only impacting themselves, but their co-workers, family, friends and even patients. As explained to us by one paramedic who eventually "crashed" and was diagnosed with PTSD:

A paramedic with PTSD doesn't stop with a paramedic – it continues to his patients, it continues to his peers, his relationships with his supervisor, with his manager, with his wife, with his kids... I became a very productive successful paramedic and manager until I crashed... until it all became too much.

56. Many that contacted us suggested increased education and awareness about the cumulative effects of stress, the signs and symptoms to watch out for, and some resiliency tactics could be helpful in recognizing when it might be time to obtain assistance.
57. In addition, we were told that hearing from peers who have been impacted by operational stress and listening to how they recognized when they needed help and what they did to obtain that help would assist in de-stigmatizing and demystifying the issue of operational stress injuries.

3.4 The Role of Emergency Medical Dispatchers - Do You Know What We Do?

58. A common theme from emergency medical dispatchers that contacted us was the feeling that the operational stress associated with their position has not been recognized by the service. Examples of this included not being invited to participate in debriefings delivered by the service after traumatic calls that a dispatcher was involved with because they "weren't there."
59. One senior emergency medical dispatcher felt the failure of the service to recognize the stress associated with the job was reflected in the fact that they do not receive any training on the issue of operational stress injury. Receiving such training, he felt, would "show that (the organization is) aware that what you do is difficult and it's not always easy to do your job." Currently, this dispatcher felt the training is more focused on addressing performance issues and following the script that emergency medical dispatchers are required to adhere to. He explained:

There's a disconnect in goals here, in their goal to train and our goal just to cope. There needs to be a change in what they're focussing on. I think if they focussed on the health and well-being of the employee then they would have better acting and better performing employees.

60. Others expressed concern over the lack of understanding that clinicians at the City of Toronto Employee Assistance Program (EAP) have about the nature of the emergency medical dispatcher role, with some recalling that they would spend an entire session just explaining to a counsellor what the job entails. This, we heard, did not generate confidence that they would get the help they needed.
61. One Commander said she had received feedback from emergency medical dispatchers about their less than satisfactory experience accessing assistance from external clinicians. "So there's a barrier even in that initial accessing," she said, "even if it's just a perception. People just feel like they won't bother to access it."
62. Although some felt they had received support from their supervisors, others believed that any support they received, such as a call to their home if they were sick, was not authentic and lacked sincerity, or worse, constituted a thinly veiled attempt to find out when that person would be returning to work.
63. One emergency medical dispatcher, struggling to cope with her operational stress injury, shared with us some poetry that she wrote about her experiences. The sentiments expressed in her poetry reflect the experiences that we heard from other dispatchers.

I can't show I'm weak,
What oh what is wrong?
I'm here to help others,
I'm supposed to be strong,

These invisible scars,
Build a wall deep within.
No one can see these,
So the hiding begins.

The wall starts to break,
I'm feeling all alone.
What should I do?
I pick up the phone.

But who will listen?
And where do I turn?
No one understands,
So I'm alone to churn.

4.0 History of the Toronto Paramedic Services

64. TPS is the largest municipal paramedic ambulance service in Canada. It is responsible for providing emergency medical response services for the City of Toronto, encompassing 650 square kilometres and a daytime population of 3.5 million people.
65. The history of TPS goes back to the early 19th century when the first organized ambulance service in Toronto (then the Town of York) was started on June 22, 1832. Over fifty years later, in 1888, the Toronto Police Ambulance Service was formed to deal with emergency calls in Toronto, with formal training for ambulance attendants first being conducted in 1889 and consisting of a five-day course. In August 1933, the Department of Public Health took over the ambulance service from the Toronto Police, which it continued to operate until December 31, 1966.
66. In January 1967, the Department of Emergency Services was formed by the Municipality of Metropolitan Toronto. This was as a result of a recommendation for the municipality to take over the operation of all public ambulance services serving the municipality, as well as establishing and operating an ambulance dispatch centre to coordinate all ambulance calls.
67. In 1968, the provincial Ministry of Health became more involved in the regulation, standardization and operation of ambulance services across the province. This led to the creation of the York Toronto Ambulance Service. The York Toronto Ambulance Service continued until 1975, when the Department of Ambulance Services was formed and became responsible for being the sole ambulance service provider for the Municipality of Metro Toronto. The Department of Ambulance Services amalgamated five remaining private services, the York Toronto Ambulance Service, and the Department of Emergency Services into a single ambulance service.
68. In 1981, the headquarters for Toronto Ambulance was opened at 4330 Dufferin Street, where it remains today.
69. In 1998, with the amalgamation of the seven municipalities in Metropolitan Toronto area into the City of Toronto, the Department of Ambulance Services became Toronto Emergency Medical Services.

70. In 2014, Toronto Emergency Medical Services was renamed the Toronto Paramedic Services.⁹

4.1 The Provincial Role in the Delivery of Land Ambulance/Paramedic Services

71. In January 1998, the Ontario Ministry of Health and Long-Term Care initiated a process that saw the transferring of the responsibility of the provision for land ambulance services to municipalities and designated delivery agents, with the Ministry providing 50 per-cent of the costs associated with land ambulance services.¹⁰ In addition, the Ministry established standards for the delivery of land ambulance services and monitors the standards to ensure compliance.¹¹ Before a service can commence the provision of land ambulance services, it must obtain a certification from the Ministry.
72. Typically, to become a paramedic in Ontario, this will include attending a Paramedic Program at an Ontario college of applied arts and technology for two years and, after successful completion, undergoing a provincial certification examination known as the Advanced Emergency Medical Care Assistant (A-EMCA).¹² Once hired by a paramedic service, anyone who has successfully completed the above is entitled to practice as a Primary Care Paramedic in Ontario.¹³
73. There is also the Advanced Care Paramedic which consists of an additional year of training at an Ontario community college¹⁴ and, in most cases, requires at least some years of experience as a Primary Care Paramedic prior to entering the program.
74. Both the Primary Care and Advanced Care Paramedics are required to complete annual continuing medical education courses to maintain their qualifications and certifications. In Ontario, the function of monitoring the patient care delivered by paramedics is provided through base hospital programs. A medical director at each base hospital program is responsible for certifying and delegating to a paramedic the performance of certain controlled medical acts for patients

⁹ Toronto Paramedic Services "History of Toronto Paramedic Services" (undated) online: <http://torontoparamedicservices.ca/history-of-toronto-paramedic-services/>.

¹⁰ The Regional Municipality of Metropolitan Toronto has had ownership of ambulance services since 1975. When Ontario downloaded ambulance services to municipalities, the Department of Ambulance Services for Metro Toronto was not affected.

¹¹ Ministry of Health and Long-Term Care "Emergency Health Services: Land and Air Ambulance" Online: http://www.health.gov.on.ca/english/providers/program/ambul/ehs_mn.html.

¹² Paramedics who have not graduated from an Ontario College Paramedic Program can apply for certification through an equivalency process in which they must demonstrate adequate paramedic education, and must successfully pass the A-EMCA theory exam.

¹³ The functions of a PCP include: emergency patient care; cardiopulmonary resuscitation (CPR); patient immobilization; oxygen therapy; basic trauma life support and; blood glucose testing.

¹⁴ The Toronto Paramedic Services is able to deliver the Ontario Advanced Care Paramedic Program.

experiencing acute injury or illness.¹⁵ The base hospital medical director also monitors the quality of care provided by paramedics.

75. Within the TPS, a Primary Care Paramedic is referred to as a Level 1 paramedic, while Advanced Care Paramedics are Level 3. There are also Level 2 paramedics, which includes all of the responsibilities of the Level 1 paramedic but is further enhanced with additional training and skills. The TPS no longer operates a Level 2 training program, although there are Level 2 paramedics working with the service.
76. With regard to emergency medical dispatchers, the TPS requires candidates be certified as an advanced emergency medical dispatcher prior to obtaining an offer of employment. This entails completing a three-day course through the International Academies of Emergency Dispatch. Candidates must have graduated from secondary school and have current certification in CPR and first aid.
77. Upon hire by the service, dispatchers begin a two-phase dispatch training program focusing on responding to and processing 911 calls through in-class and practical training. Members will then complete dispatch training with the instruction and support of a preceptor, who evaluates their progress.

4.2 Structure of the Toronto Paramedic Service

78. TPS currently employs 934 full-time paramedics, 181 part-time paramedics, and 125 emergency medical dispatchers, 19 of which are senior dispatchers. There are 121 members of management.¹⁶
79. There are four main service divisions within the TPS, each one headed by a Deputy Chief. The Chief, also the General Manager, is responsible for the overall operation of the service.
80. The Operations Division is responsible for the operational supervision and support of the emergency medical care and transport of patients by paramedic ambulance crews on a 24/7 basis. There are four service districts across the city¹⁷ and a fifth district designated for specialized operations.¹⁸ Within the four service districts there are 47 ambulance stations across the city, covering 632 square kilometres. Each of the districts has a head office and is led by a Commander, who reports to the Deputy Chief of Operations, and includes a

¹⁵ The *Regulated Health Professions Act*, 1991, S.O. 1991, c. 18, s. 27(2) lists the controlled acts that a physician or his or her delegate can perform and is comprised of 13 main acts. Primary care paramedics are permitted to perform eight of the 13 procedures when the paramedic is certified under the base hospital physician (*Ambulance Act*, R.S.O. 1990, c. A. 19, O. Reg 257 / 00 8 (1)(b) sched. 1.)

¹⁶ The rest of the workforce includes 59 in garage/scheduling/equipment services and stores, 48 clerical and technical, and 24 exempt professional and clerical.

¹⁷ District 1 – North West; District 2 – North East; District 3 – South West; District 4 – South East.

¹⁸ Specialized operations include the Public Safety Unit, the Chemical, Biological, Radiological, Nuclear, Explosive Unit, the Emergency Support Unit and the Emergency Response Unit.

variable number of superintendents who in turn have paramedics that fall under their authority.

81. The Central Ambulance Communications Centre (CACC) is a communications and dispatch service that processes approximately 334,000 calls per year, responds to another 272,000 requests for services which results in the transportation of about 210,000 patients per year. The CACC, which is located at the service's headquarters on Dufferin Street, has its own Deputy Chief and Commander. As in the Operations Division service districts, there are also superintendents within the Communications Centre.
82. The CACC is responsible for the training of emergency medical dispatchers, a responsibility that is given to the Commander, Education and Quality Improvement, which also has superintendents. There are Deputy Commanders within the Communications Centre, which is a management role. Generally, they liaise between the paramedics and superintendents on the road and the operations of Communications Centre. Their role is to oversee the operations and efficiency of the system across the city as well as to notify superintendents, or, as needed, the on-call team of anything that may need to be escalated or addressed beyond the initial paramedic response.
83. Operational Support provides logistical resources services, including fleet operations, facility maintenance, staff scheduling and materials management. As the name would suggest, this service division supports the Operations division, including responsibility for the maintenance and distribution of medical equipment and supplies.
84. The Program Development and Service Quality division includes: Education and Development, which coordinates the annual Continuing Medical Education for all paramedics and Superintendents as well as recruiting paramedics; Professional Standards, which is responsible for complaint investigation; media relations; multimedia communications; and community para-medicine, including the maintenance of automated external defibrillators located across the city.
85. Although not listed on the website, or otherwise noted on the service's directory, the Program Development and Service Quality division also houses the psychological support services of the TPS. This includes the staff psychologist, who reports to the Deputy Chief of Program Development and Service Quality.
86. My investigators heard repeatedly how the TPS is widely considered to be a leader with respect to addressing stress among paramedics and emergency medical dispatchers. This is largely attributed to the fact that the TPS is the first, and remains the only, paramedic service in Canada to have a staff psychologist.

5.0 Components of the Psychological Support Program

87. The Psychological Support Program for the TPS has been in existence in various forms since the middle of the 1980's, beginning with the first staff psychologist in August 1986. Employees of the TPS have also been able to access various services from the City of Toronto's EAP as well as an employee based Peer Support Team (now referred to as the Peer Resource Team) that was initiated by the first staff psychologist.
88. From 2011 to 2013, the current staff psychologist conducted a needs assessment of the psychological services in which 100 percent of paramedics and emergency medical dispatchers participated. This resulted in, among other things, changes to the Peer Resource Team, and a focus on prevention and early intervention.
89. The components listed below were all included as part of the Psychological Support Program in documents that were provided to my office.

5.1 The Peer Support Team/Peer Resource Team

90. The Peer Resource Team has been in existence in some form for approximately 26 years. According to the TPS, it was developed because trained peer counsellors "are able to quickly understand, empathize with, and speak appropriately to the types of calls, the hours of work, and the stress that paramedics and emergency medical dispatchers experience." It was also felt that some employees may be more comfortable first reaching out to a peer for guidance and direction in dealing with stress.
91. With the second staff psychologist, members of the Peer Resource Team (then Peer Support Team) volunteered to participate in the program. Members were provided with training on how to assess situations, provide initial counselling and guidance to staff in finding appropriate resources for assistance. According to a 2005 document prepared by the TPS, the staff psychologist was responsible for the training and supervision of the 20 members on the Peer Support Team, including approximately 12 hours of training per year for each member.¹⁹
92. Members of the peer team were also bound by an obligation of confidentiality. A member of the team could not reveal to others about even meeting with a staff member unless permission was provided by the staff member. Exceptions included the requirement to report situations in which there was a concern that an individual may harm him or herself or others or where there was suspected child abuse.²⁰

¹⁹ Toronto EMS Chief Bruce Farr, Staff Report: "Toronto EMS Staff Psychologist Services" presented to the Community Services Committee 21 October 2005.

²⁰ Dr. Gerry Goldberg, *Building Resiliency: EMS Stress and the Peer Support Team* (unpublished: for internal use by Toronto Paramedic Services) (February 2007).

93. Over the course of 2011 and 2012, the current staff psychologist undertook a redevelopment of the peer team, resulting in the current Peer Resource Team. The team was reselected and reformulated, involving a number of changes:
- A new, standardized selection process, based on anonymous peer nominations and distribution of team members across years of service, shift schedule and employee groups;
 - Psychological screening of prospective members, as well as a panel interview;
 - Stringent confidentiality requirements, such as adherence to the College of Psychologists of Ontario confidentiality standards and zero-tolerance for confidentiality breaches;
 - Standardized psychological training based on industry standards;
 - Burnout prevention; and
 - Ongoing supervision and training by the staff psychologist, including routine reporting of services rendered to members to the staff psychologist, on an anonymous basis.
94. The Peer Resource Team includes both paramedics and dispatchers. They address the spectrum of critical incidents, cumulative stress, as well as other workplace and personal matters. Like the staff psychologist, members of the Peer Resource Team are on call 24/7 for critical incidents and crisis situations on an urgent and as needed basis.
95. The current Peer Resource Team is a group of 15, including a retired superintendent and a member of the Toronto Fire Services. The majority of the members are paramedics, but there are also some dispatchers, superintendents and one commander.
96. Each Monday morning, the TPS provides the list of on-call/available peer members for the coming week to all management and supervisor staff as well as superintendents to provide to staff. Employees of the TPS are free to contact members of the Peer Resource Team on their own. Due to recent concerns about difficulties in obtaining contact information for peer members, the TPS is in the process of developing *Mental Health and Wellness* posters to distribute across ambulance stations and TPS buildings that includes contact information for each member of the Peer Resource Team.
97. It was abundantly apparent throughout the course of this investigation that the Peer Resource Team is highly regarded, both inside and outside the service. In fact, when we spoke with other paramedic services across Ontario and Canada, many told us that they were modelling their own peer support programs after the model used by the TPS.
98. One particularly noteworthy point of praise for the Peer Resource Team came from the Ontario Ministry of the Attorney General.

99. In the aftermath of the March 28, 2014 shooting that took place at the Brampton courthouse, members of the peer team along with the staff psychologist provided support to staff at the courthouse at the request of the Ministry. In a letter co-written by the Deputy Attorney General and the Chief Administrative Officer/Assistant Deputy Attorney General, praise was effusive for the team. Comments were made on the quality and levels of support provided in the days following the shooting. The letter noted that: "Our ability to reduce workplace refusals, sick time, and other costs associated with staff anxiety and stress can be directly attributed to the supports received in the days following the event."
100. Although the Peer Resource Team is widely praised, we were told that there is nothing within the service in the way of protocols, documents, guidelines or policies that govern the team or the role of its members.

5.2 Employee Assistance Programs

101. Employees of the TPS, just like any employee of the Toronto Public Service, are eligible to access the EAP. It is also available to eligible family members of the TPS and offers confidential short-term individual, couple or family counselling, information and referral services on a 24/7, 365 days a year basis. The EAP offers:
- *Personal issues*, such as anxiety/depression, addictions, workplace issues, stress;
 - *Relationships*, including conflict, communication, separation/divorce, couples;
 - *Legal advisory*, including telephone access to lawyers and referrals to lawyers for in-person consultation;
 - *Financial counselling*, including debt management services;
 - *Workplace issues* such as trauma, critical incident response, and psychological first aid training.
102. EAP employs five program counsellors, all with at least 15 years minimum experience and a Master's degree. They are either social workers or psychological associates and all are members of their respective professional associations. We were also advised that all counsellors would have a background dealing with critical incident stress.
103. Contact with EAP is confidential.
104. In the event that long-term or specialized counselling is required, EAP is able to assist members in obtaining a referral to community resources, including resources available outside Toronto. In addition to this, through the staff psychologist, TPS launched an initiative to identify community mental health providers with experience providing care to first responders and dealing with

issues commonly experienced by first responders. The resulting referral list is maintained by the staff psychologist and is also provided to EAP counsellors.

105. Members of the Peer Resource Team are provided information about EAP to offer to paramedics and dispatchers that may contact them. Contact information about EAP has also been shared as part of the weekly on-call schedule.
106. In the past, EAP counsellors have put on workshops for TPS employees and family members on wellness-related topics, such as dealing with shift work and relationship issues. More recently, an EAP counsellor has been asked to provide psychological first aid training to members of the Peer Resource Team and a workshop titled "Managing and Assisting the Troubled Employee" for managers.
107. Statistical information is collected by EAP. The statistical reports include the general types of problems that clients have sought assistance for and the number of counselling hours provided. The data is aggregated and protects the identity and confidentiality of anyone who accesses the service.
108. My office requested EAP statistics for the TPS from the years 2010 to 2015. Below is a table of the statistics that we were provided regarding EAP usage by TPS employees and their families.

	Total Services	Legal Services	Financial Services	Management Consultations	Total # of Face to Face and Telephone Counselling	# of cases where reason for contact was noted as 'work related' or 'mental health'
2010	70	15	2	1	52	14
2011	79	37	4	1	37	14
2012	45	18	2	1	24	8
2013	66	22	1	6	37	14
2014	60	18	2	4	36	14
2015	66	18	1	6	41	24

109. TPS employees who are also members of the Local 416 bargaining unit are able to access an Employee Assistance Program operated by Family Services. Based on the brochure that was provided to my office, it appears that the services available through Family Services are consistent with EAP.

5.3 Medical Stress Leave

110. Dating back to 2002 collective bargaining between TPS and Local 416, the service agreed to add "first-of-its-kind" contract language allowing paramedics the option to book "out of service" after a difficult or critical call.²¹ According to the TPS, the inclusion of this language in the contract "formalized a longstanding practice" within the TPS of booking paramedics off after a difficult call, such as those involving a deceased child or multiple deaths.
111. The time off that can be taken by a paramedic ranges from a minimum of one hour up to two days. If the paramedic feels they are unable to complete the shift as a result of the call, he or she will be allowed to leave their shift, without penalty to their sick hours, lieu time and or vacation hours. Additionally, if in the opinion of the paramedic's physician and/or supervisor, the paramedic requires additional time, the paramedic may be excused from duty up to two consecutive days without loss of pay or benefits or incurring any use of sick, lieu or vacation hours.
112. The paramedic's superintendent is required to submit documentation detailing the stress claim to the WSIB should the absence of the paramedic extend beyond the day or the incident. If the claim is subsequently approved by the WSIB, then the medical stress leave is converted to WSIB for the purposes of statistics.
113. Internal documents prepared by the TPS tracking medical stress leave hours from 2005 to the first quarter of 2012, indicate the total hours have dropped from a high of 1,604.98 hours in 2005, to 608.69 hours by the end of 2011. The first quarter of 2012 recorded 131.98 medical stress leave hours, which was the lowest Q1 total and the second lowest total out of any quarter since the tracking of medical stress leave hours began.
114. Emergency medical dispatchers, who are members of CUPE Local 79, do not have similar language in their collective agreement. We were told that, after difficult or otherwise traumatic calls, dispatchers are offered time away from the phones and assistance is offered and/provided. My office was also provided with information that, sometimes, dispatchers that are unable to return to their shift after an upsetting call are able to book off the rest of their shift, with the hours counting against their sick time.

5.4 Wellness Committee

115. A Wellness Committee was established by the TPS in 2010. The committee is responsible for developing and recommending strategies to promote wellness among employees and their families. Originally, representation on the committee

²¹ Collective Agreement between Toronto Civic Employees' Union, Local 416 – Canadian Union of Public Employees (CUPE) and City of Toronto, January 1, 2012 to December 31, 2015; s.45.07, "Stress."

included paramedics, dispatchers and clerical support staff, HR staff, the staff psychologist, superintendents, a member of the Pioneers Group (represents senior and retired staff) and the Deputy Chief of Program Development & Service Quality.

116. One of the most visible contributions of the Wellness Committee was the implementation of the "Fit for Duty" promotion, whereby employees (as well as Toronto Fire Service employees) became eligible for a substantially reduced membership rate at GoodLife Fitness Clubs.
117. In 2014, the committee revised its terms of reference and proposed reducing the committee from 12 positions to eight, primarily to increase representation of paramedics and improve attendance from committee members. The revisions were never implemented and the current focus of the Wellness Committee is the "Fit for Duty" promotion, until the committee reconvenes in late 2015.

5.5 Paramedic Services Chaplain

118. The TPS has two chaplains that provide both ceremonial services, such as speaking at recruits' graduation, and individual support to staff and alumni. The chaplains are paid an honorarium for ceremonial work and often provide other services on a volunteer basis.
119. The position of a chaplain has been described as a "bridge" between the work of the staff psychologist and the Peer Resource Team. One of the chaplains has experience working with peer crisis teams and training in critical incident stress programs. A member of the Peer Resource Team who is also a chaplain will begin providing his services in that capacity as part of the Peer Resource Team. My investigators were also told that contact information for chaplaincy services will be listed on a new poster advertising psychological supports for members.

5.6 Extended Health Benefits – Psychological Coverage

120. As outlined in the collective agreements for paramedics and dispatchers, with CUPE Local 416 and CUPE Local 79 respectively, benefits coverage for psychological services are limited to \$300 per person in a benefit year.
121. Members of the Toronto Police Services receive \$3,500 coverage for psychological services, while members of the Toronto Fire Services receive \$1,000.

5.7 Workplace Safety and Insurance Board Benefits

122. In Ontario, workers are covered by provincial no-fault, collective liability insurance. The WSIB administers claims for compensation and determines their eligibility. Workers who are injured or ill due to their work are entitled to benefits

for loss of earnings and health care. The WSIB also facilitates return to work when workers are able.

123. The City of Toronto is a WSIB Schedule 2 employer, which means it self-insures and pays all benefit compensation, while the WSIB administers the entitlement and payment of benefits to injured workers.
124. Ontario employees may be entitled to WSIB benefits if they experience "traumatic mental stress" (TMS) as a result of an "acute reaction to a sudden and unexpected traumatic event arising out of and in the course of his or her employment" that is not the result of the "employer's actions or decisions related to the worker's employment."²²
125. The employee must be diagnosed with an "Axis 1" clinical diagnosis on the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV). These include anxiety disorders such as PTSD, mood disorders, dissociative disorders and sleep disorders.
126. A TMS reaction can be either immediate (within four weeks of the event), or delayed (after that timeframe). In cases of delayed onset, there must be clear and convincing evidence linking it with a traumatic event in the course of employment. Benefit entitlement can also be awarded as a result of cumulative traumatic events. However, the "final straw" must be an acute reaction to a specific traumatic event. The WSIB acknowledges that some occupations, such as emergency response work, will expose workers to multiple traumatic events. Even if a worker has been previously exposed to and able to tolerate similarly shocking events, benefit entitlement is not precluded.
127. Some provinces have amended workers' compensation legislation to include a presumption that traumatic mental stress in a first responder is a result of their employment. This facilitates faster access to benefits and covered psychological treatment.
128. Alberta was the first province to add presumptive entitlement to their legislation in 2012. In June 2015, Manitoba introduced a Bill to add a presumptive clause that would extend to all workers, not just first responders.
129. In Ontario, there have been five unsuccessful attempts to add a presumptive clause to the *Workplace Safety and Insurance Act*. Currently, there is a Bill to introduce presumptive legislation that will have its second reading in December 2015.

²² *Workplace Safety and Insurance Act*, 1997, S.O. c. 16, Sched. A, s. 13. WSIB policy clarifies that a "sudden and unexpected" event is: clearly and precisely identifiable; objectively traumatic; and unexpected in the normal or daily course of the worker's employment or work environment.

6.0 "Breaking new ground" – The Hiring of a Staff Psychologist

130. Of all the parts of the Psychological Support Program, the position of the staff psychologist clearly has the highest profile.
131. The first staff psychologist was hired by the then Department of Ambulance Services in August 1986. Described at the time as "breaking new ground" in a *Toronto Sun* article,²³ the service has had three staff psychologists.
132. We spoke with a now retired Deputy Chief who recounted the decision-making process that led to the hiring of the first staff psychologist. He noted that in the early 1980's there was a growing awareness about PTSD and that Toronto tended to be on the "cutting edge" of addressing staff stress issues. He recalled that he and another supervisor attended a conference in the United States where the issue of critical incident stress was discussed. Upon returning from the conference, armed with information about the potential impacts of critical incident stress on workers, events were set in motion to have City Council approve the hiring of a staff psychologist.
133. A 2005 document prepared by the TPS notes that the staff psychologist was originally retained by the service to help deal with critical incident stress, a condition that was believed to affect paramedics and dispatchers following major multi-patient or disaster-like incidents. The document notes that the "essence" of intervention after critical incident stress is the recognition that paramedics and dispatchers are "human as anyone else" and that they are "not psychologically immune to the tragedies and misfortune they must deal with on a regular basis."
134. A former Chief of Toronto EMS who was Deputy Chief at the time that the first staff psychologist was hired, told my investigator that there was no "blueprint" for the operation of psychological services within an ambulance service. In fact, he believed Toronto's decision to hire a staff psychologist "shocked" other services.
135. When we spoke with the service's first staff psychologist, she said that her hiring was primarily an attempt to assist the service to address sick time among staff from the psychological perspective. She felt that the service's decision to hire a psychologist at that time was "highly progressive" and credited the leadership team at TPS and City Council for making the decision.

²³Linda Barnard, "Sirens and Stress", *Toronto Sun*, March 15, 1987, p. 60.

6.1 Role of the Staff Psychologist – 1986 to Present

136. The TPS does not have formal documentation outlining the role and responsibilities of the staff psychologist dating back to 1986. Based on evidence that we obtained the initial responsibilities of the first psychologist included:
- Meeting with recruits prior to beginning on the road or in the call centre;
 - Educating staff on how to recognize and cope with critical incident stress, including signs, symptoms, self-care and when they should contact her for assistance;
 - Training management on how to manage incidents involving staff from a psychological perspective;
 - Education for paramedics and their spouses on the stresses associated with the work;
 - On call 24 hours a day to respond to workers that needed assistance;
 - Initiating courtesy check-in calls with workers that were involved in stressful calls; and
 - Conducting short-term crisis intervention sessions with staff.²⁴
137. In an October 21, 2005 document prepared by the Chief of TPS on services provided by the staff psychologist, it is noted that the role of the psychologist evolved and expanded from intervening to address issues of critical incident stress to preventing the effects of critical incident stress.²⁵ This included focusing more broadly on workplace wellness and support needs of staff in light of the recognition that "often, what happens in a paramedic or dispatcher's personal life may have direct crossover into their professional life, and vice versa."
138. Based on our review of the documents provided by the TPS as well as interviews with staff, it appears that the second staff psychologist was primarily involved in speaking with staff one on one as well as engaging in research and preparing publications related to the topic of stress and the work of paramedics. One of the main documents provided was a 70-page booklet prepared by the second staff psychologist that included coping tips and strategies on the topics of developing and maintaining a resilient lifestyle, dealing with critical incidents, and (developing) compassion skills.
139. With the retirement of the second staff psychologist in January 2010, TPS saw an opportunity to improve the role of the staff psychologist, as well as reinvigorate the Psychological Support Program. The same retired Deputy Chief who was involved in the hiring of the first staff psychologist was involved in the hiring of the current staff psychologist. He explained to us the approach taken by the service with the hiring of the current staff psychologist:

²⁴ As there is no documentation from the TPS from that time explaining the role of the staff psychologist, this information is taken from witness interviews.

²⁵ Toronto EMS Chief Bruce Farr "Staff Report: Toronto EMS Staff Psychological Services" presented to the Community Services Committee (21 October 2005) p. 2.

...(W)e wanted to take a totally different approach to the psychologist. Because (the previous Staff Psychologist) had a little office in a closet in the back that he never saw anybody in... So we wanted to take a totally different approach. We wanted the psychologist to be very visible – here's our psychologist. She's not out there just for the paramedics but she's in here as well with us, to help us to be able to deliver what we need to deliver to decrease whatever stressors are out there.

140. He told us that it was the desire of the TPS to include the staff psychologist as a part of the organization, rather than as something separate; to really connect and integrate the position within the organization so that the services provided were "much more visible to the staff and seen to be more part of the division as opposed to someone out there."
141. The current staff psychologist recalled that around the time she was hired, senior management advised her that they were "very serious about making significant changes" to the organization's psychological support services, including increasing employee engagement with accessing psychological services and implementing programs to better support paramedics and dispatchers.
142. In our review of the documents, we were able to find only a few references to the role and function of the current staff psychologist. One reference was a brief description of the role on the now defunct Toronto Emergency Medical Services website:
- Involved in acute psychological care for Toronto EMS staff;
 - Supervision of the Peer Support Team;
 - Facilitation of appropriate referrals;
 - Program and policy development;
 - Teaching;
 - Research; and
 - Regular attendance on ride outs.²⁶
143. There is currently nothing on the TPS public website or intranet site that provides information about the role and function of the staff psychologist or any details about the service's Psychological Support Program.

²⁶ Toronto Emergency Medical Services "Psychological Services." online: <http://www.torontoems.ca/main-site/service/psychological.html>.

7.0 Operational Stress Injury and Paramedics

144. Although PTSD makes up a low proportion of operational stress injuries overall,²⁷ it is generally considered to be the most well-known and serious. It also appears to be the most studied of operational stress injuries and most measures of prevalence in the literature focus on PTSD.
145. Signs and symptoms of PTSD include re-experiencing traumatic events, emotional numbing, and hyper arousal/awareness.²⁸ Disassociation following a traumatic event is considered to be a particularly important warning sign, as it suggests an inability on the part of the individual to process his or her feelings following an event. This in turn is linked to an increased risk of PTSD. In order to receive a formal diagnosis of PTSD, an individual must be suffering from symptoms for more than 30 days. Delayed onset of PTSD can also occur over six months after exposure to a stressful event. There is a high co-occurrence of PTSD with substance use and major depressive disorder²⁹ which increases the risk of suicidal behaviours.
146. Within the general population, Tuckey et al report the prevalence of PTSD is one to six percent,³⁰ while Van Ameringen et al show that the prevalence of PTSD in the population is 2.4 percent.³¹
147. Studies looking at the prevalence of PTSD within first responders have shown a range, with one study putting the number as high as 30 percent.³² The latter study presented findings indicating higher rates of PTSD in paramedics and firefighters than police officers, suggesting the type of trauma and perhaps training are linked to the risk of PTSD. Another study suggested that paramedics have the highest rate of PTSD among first responders.³³
148. Studies examining the prevalence of PTSD within paramedics offer a range. A 2007 study of Brazilian ambulance workers found a prevalence rate of six percent.³⁴ A 2004 study of ambulance workers in the United Kingdom found that

²⁷ Adams, B. D., S. A. Davis, A. Brown, E. Filardo, and M. H. Thompson. *Post Traumatic Stress Disorder (PTSD) in Emergency Responders Scoping Study: Annotated Bibliography*. Rep. no. DRDC-RDDC-2014-C18. Ottawa: Defence Research and Development Canada - Centre for Security Science, November 2013.

²⁸ *Ibid.*

²⁹ Van Ameringen, M., Mancini, C., Patterson, B. and Boyle, M. H. (2008), Post-Traumatic Stress Disorder in Canada. *CNS Neuroscience & Therapeutics*, 14: 171–181.

³⁰ Tuckey, M. R., and J. E. Scott (2014), Group Critical Incident Stress Debriefing with Emergency Services Personnel: A Randomized Controlled Trial, *Anxiety, Stress & Coping: An International Journal* 27.1: 38-54.

³¹ Op. cit.

³² Adams, B. D., S. A. Davis, A. Brown, E. Filardo, and M. H. Thompson. *Post Traumatic Stress Disorder (PTSD) in Emergency Responders Scoping Study: Literature Review*. Rep. no. DRDC-RDDC-2014-C18. Ottawa: Defence Research and Development Canada - Centre for Security Science, November 2013. Online: http://cradpdf.drdc-rddc.gc.ca/PDFS/unc195/p800202_A1b.pdf.

³³ Drewitz-Chesney, C. "Posttraumatic Stress Disorder among Paramedics: Exploring a New Solution with Occupational Health Nurses Using the Ottawa Charter as a Framework." *Workplace Health & Safety* 60 (2012): 257-63.

³⁴ Berger W, Figueira I, Maurat AM, Bucassio EP, Vieira I, Jardim SR, Coutinho ES, Mari JJ, Mendlowicz MV. (2007) Partial and full PTSD in Brazilian ambulance workers: prevalence and impact on health and on quality of life. *J Trauma Stress*, 20(4), 637-42.

22 percent of respondents to a survey met the criteria for PTSD.³⁵ That same study noted one in ten respondents reported clinical levels of depression and 22 percent reported clinical levels of anxiety. Another study found a prevalence rate for PTSD of 22 percent among urban paramedics.³⁶

149. Paramedics, like other first responders, are routinely exposed to potentially traumatic events in the course of their work. Research has shown that repeated exposure to these events can lead to psychological exhaustion, with each new exposure becoming another risk factor for the development of PTSD.³⁷ Cumulative stress has also been linked to other operational stress injuries as well.³⁸
150. Hegg-Deloye et al., in a review of a number of studies, found that paramedics are exposed to acute and chronic stress risk factors in the course of their work which can lead to a high prevalence of PTSD, sleeping disorders and obesity.³⁹ Another study found that prolonged duration, from two days to over a week, of acute stress reaction after a critical incident is associated with increased symptoms of post-traumatic stress and depression, and, to a lesser extent, burnout.⁴⁰
151. A survey of paramedics at an Ontario service found that the operational stresses associated with working on an ambulance independently increases the risk for a post-traumatic stress reaction to a critical incident.⁴¹ The same research found that critical incident stress interacts with operational stress to further increase this risk. In a study of Dutch paramedics, researchers found that high levels of chronic stressors were quite common amongst ambulance workers, and that these stressors were significant predictors of health symptoms. In particular, the researchers found that social factors within the work environment were important predictors, such as lack of social support from colleagues and supervisors, and poor organizational communication. The researchers suggested that factors such as these were significant predictors of post-traumatic response, burnout symptoms and fatigue.⁴²

³⁵ Bennett, P., Williams, Y., Page, N., Hood, K., & Woollard, M. (2004). Levels of mental health problems among UK emergency ambulance workers. *Emergency Medicine Journal*, 21(2), 235–236.

³⁶ Grevin, F. (1996) Posttraumatic Stress Disorder, Ego Defense Mechanisms, And Empathy Among Urban Paramedics, *Psychological Reports* 79.2: 483-95.

³⁷ Adams, B. D., S. A. Davis, A. Brown, E. Filardo, and M. H. Thompson. *Post Traumatic Stress Disorder (PTSD) in Emergency Responders Scoping Study: Annotated Bibliography*. Rep. no. DRDC-RDDC-2014-C18. Ottawa: Defence Research and Development Canada - Centre for Security Science, November 2013.

³⁸ Paramedic Chiefs of Canada Briefing, *supra* note 5.

³⁹ Hegg-Deloye S, Brassard P, Jauvin N, Prairie J, Larouche D, Poirier P, Tremblay A, Corbeil P (2014) Current state of knowledge of post-traumatic stress, sleeping problems, obesity and cardiovascular disease in paramedics, *Emerg Med J*. 31(3):242-7.

⁴⁰ Halpern J, Maunder RG, Schwartz B, Gurevich M (2011) Identifying risk of emotional sequelae after critical incidents, *Emerg Med J*, 28:51-56.

⁴¹ Donnelly, E.A., Bradford, P., Mellow, R., Hedges, C., & Morassutti, P., (2013). Relative Influences of Different Stresses on PTSD in a Canadian EMS Service. *Journal of Prehospital Emergency Care*. 17(1), 132. (Refereed Abstract).

⁴² Van Der Ploeg, E., and R. J. Kleber. "Acute and Chronic Job Stressors among Ambulance Personnel: Predictors of Health Symptoms." *Occup Environ Med* 60.Suppl I (2003): i40-i46.

152. There is research suggesting that emergency medical dispatchers are at risk of developing an operational stress injury.⁴³ Although some stressors experienced by dispatchers are similar to those faced by paramedics, distinct stressors have been identified, including: low perceived status within the organizational hierarchy; an elevated sense of responsibility as intermediaries between front-line workers and civilians; and inadequate formal training.
153. Although much of the research on first responders has focused on PTSD, it is not the only injury that first responders are susceptible to. As one of the clinicians that we spoke with noted, while PTSD is the operational stress injury that comes to mind for most people, there are injuries such as acute stress disorder, major depressive disorder, substance use, anxiety disorders, panic disorders, obsessive-compulsive disorders, and others. This clinician felt that if an operational stress injury is defined as a mental health injury that occurs as a function of engaging regularly in high stress, high-threat situations, then any mental health injury that occurs as a result should be considered as an operational stress injury.

8.0 What Should Psychological Support Services Look Like?

154. We spoke with psychologists, psychiatrists and other mental health professionals to learn about their experiences and perspectives on developing programs and services for first responders, specifically paramedics, to address operational stress injuries. The investigative team also engaged in research and reviewed publications in the field that discussed this topic.
155. At the outset, it should be noted that there is no "one-size-fits-all" approach to addressing operational stress injuries within an organization. What a service chooses to offer in the way of supports and services, programs and policies, will inevitably differ from other services and will be based on factors such as size of service, location of service, resources available, both internally and externally within the community, volume and variety of calls and other factors.
156. In its briefing to the Paramedic Chiefs of Canada, the Ad-hoc Committee on Operational Stress Injury noted that there is no one "correct" place to house and develop operational stress injury services within a paramedic service, since the structure, governance and operational realities will vary from service to service.⁴⁴
157. Further, some of the clinicians that we spoke with said that paramedics are in some respects the "last group of first responders" to be recognized as having the potential to develop operational stress injuries. One clinician told us that, in her experience, getting paramedics to come forward and obtain assistance has been tremendously difficult.

⁴³ Gurevich, M., Halpern, J., Brazeau, P., Defina, P. S., & Schwartz, B. (2009). Frontline Stress behind the Scenes: Emergency Medical Dispatchers. *Tema Conter Memorial Trust Research*.

⁴⁴ Paramedic Chiefs of Canada briefing, *supra* note 5, p. 13.

158. There is not as much in the way of established services and programs within paramedic services in Canada to address operational stress injuries. As a matter of fact, many individuals that we spoke with, both inside and outside TPS, considered Toronto to be the leader.
159. It has been noted that there is a lack of research and evidence in the area of paramedic services and operational stress injuries.⁴⁵ Implementing systems to address operational stress injuries founded on evidenced-based research, although desirable,⁴⁶ can therefore be challenging in the face of a lack of such clear evidence.
160. Dr. Nicholas Carleton, an Associate Professor of Psychology at the University of Regina, has researched trauma for 15 years, including with military and first responder organizations. Dr. Carleton has published extensively in the field and has been described as Canada's "most published researcher regarding trauma and stressor-related reactions."⁴⁷
161. Dr. Carleton told my investigators that there is still much that needs to be learned in the field of operational stress injuries and providing "answers" on how to address the issue, particularly with regard to paramedics. He noted that, in his experience dealing with first responder organizations, the issue is not recognizing that there is a problem with respect to operational stress injuries, but the challenge is more on deciding how to address it. He explained:

I think (first responder organizations) then run immediately into the problem that I mentioned with respect to research. They say tell me exactly what to do next, based on the evidence, so then that I can argue it to my minister or whomever that we need to invest those resources in that way.

Now you end up back in the systemic problem again. Because I can't tell you exactly. I can give you some good ideas, and I'm willing to stand by them as good ideas. I can tell you that they are drawn from cross-sectional and ad hoc evidence. But I can't tell you for sure.

162. Several recent publications and documents have identified areas where organizations interested in this topic could target efforts in terms of developing a program to address operational stress injuries. Rather than highlight specific strategies, these documents have suggested broad areas of focus, including:⁴⁸

⁴⁵ *Ibid* p. 16.

⁴⁶ The Mental Health Commission of Canada and the Public Services Health & Safety Association, "Supporting the Mental Health of Ontario's Emergency Services Workers" (June 2015).

⁴⁷ Paramedic Chiefs "Abstract: Mental Health in First Responders" (17 December 2014) <http://www.paramedicchiefs.ca/webinar-abstracts/abstract-mental-health-in-first-responders-17-december-2014/>.

⁴⁸ This includes the 2014 Operational Stress Injury in Paramedic Services briefing to the Paramedic Chiefs of Canada, *supra* note 5; the 2014 Ontario Ministry of Labour Roundtable on Traumatic Mental Stress, online at

- Prevention, including training and education;
- Culture and stigma;
- Treatment, including service provider recognition of the uniqueness of first responder work;
- Intervention/response following incidences;
- Research and standards; and
- Follow up and support for members.

8.1 Making a Statement – Psychological Health and Wellness Strategy

163. Many of the clinicians that we spoke with felt that first responder organizations, by virtue of the nature of their work, should be the organizations that are setting the "gold standard" when it comes to provision of psychological and mental health care. For some, this meant having a clear and defined strategy or plan in place to address this issue.
164. In Alberta, as part of a review considering psychological support services for paramedics, the Emergency Medical Services at Alberta Health Services is currently developing a comprehensive psychological health and safety plan. The plan, which is being developed by a Psychological Health and Safety Advisory Committee,⁴⁹ has developed a multi-faceted approach to addressing the psychological health and safety of paramedics:
1. Education and Evaluation – this includes linking up with educational institutions to provide paramedics with resiliency and coping skills. Work will also be done to consider evaluation tools to better understand the stressors of practitioners as they enter the profession in the hopes of developing a "baseline" of stress;
 2. Building and Supporting – will focus on how the organization is assisting paramedics cope with professional and personal stresses. This will include developing programs and initiatives to respond to the day-to-day psychological health challenges faced by paramedics;
 3. Response – how the organization responds when there's been an identified psychological health and safety issue, such as a traumatic call;
 4. Recovering and Re-integrating – includes return-to-work issues, as well as considering programs and resources to support paramedics in

<http://www.labour.gov.on.ca/english/hs/pdf/mentalstress.pdf>, and the 2015 report by the Mental Health Commission of Canada and the Public Services Health and Safety Association, *supra* note 45.

⁴⁹ The committee is composed of representatives from management, frontline practitioners from across the province, mental health professionals, the Alberta College of Paramedics and the Workers' Compensation Board.

their return to work. This includes preparation for the possibility that the individual may not be able to return to the position.

165. Another Alberta example is the Psychological Services Division of the Calgary Police Service. The division, which has been referred to as "innovative",⁵⁰ created a booklet that outlines the philosophy of the division, program mission and values, a description of its various services, and the goals and challenges associated with delivering its services.
166. TPS has not developed its own psychological health and safety plan or strategy. Many within TPS spoke enthusiastically about the recently created City of Toronto Psychological Health and Safety Policy as something that they could use to guide the delivery and development of their own services.
167. According to information on the City's intranet, the policy commits the City of Toronto to "continuously building on its current actions and strengths in promoting and maintaining good mental health."⁵¹ The policy, developed through the Occupational Health and Safety Coordinating Committee, includes strategies and areas to focus on, including actions to promote and enhance the general psychological health of the workforce, and the prevention or reduction of psychological health problems.⁵²
168. TPS is not alone among first responder agencies not to have developed its own psychological health and safety strategy.
169. As part of his review of the use of lethal force by members of Toronto Police Services, the Honourable Frank Iacobucci considered the psychological services and supports offered to members. In his report, he found the service lacked a comprehensive psychological health and safety management system. He noted the absence of a comprehensive statement on psychological wellness for officers.⁵³ Recommendations 33 and 34, respectively, of Justice Iacobucci's report recommended that the service create a formal statement on psychological wellness and to consider the establishment of a psychological health and safety management system for the service.
170. In its investigation of the Ontario Provincial Police's delivery of psychological services, the Ontario Ombudsman recommended that the service develop and

⁵⁰ Antoon Leenaars, Peter Collins and Deborah Sinclair "Report to the London Police Services and London community on the deaths of David Lucio and Kelly Johnson" (20 May 2008) Online:

<http://www.police.london.ca/Newsroom/PDFs/luciojohnsonreport.pdf>.

⁵¹ City of Toronto "Mental Wellness: One step at a time" Online:

<http://www1.toronto.ca/wps/portal/contentonly?vgnextoid=93aad81f3f72b410VgnVCM10000071d60f89RCRD>

⁵² The policy notes that definitions included in the document were taken from the National Standard of Canada, a national workplace mental health standard also referred to as the "National Standard for Canada for Psychological Health and Safety in the Workplace - Prevention, Promotion, and Guidance to Staged Implementation." The standard, published in 2013, is a collaboration between the Mental Health Commission of Canada and Canadian standards organizations. Online:

<http://www.mentalhealthcommission.ca/English/issues/workplace/national-standard>.

⁵³ *Ibid*, p. 182.

implement a comprehensive and co-ordinated program to address operational stress injuries. In response, the OPP tasked the Manager of Psychological Services to "develop and implement an organizational mental health strategy that is aimed at identifying a comprehensive and coordinated program" to address operational stress injuries.

8.2 The ABCs of Operational Stress Injury – The Importance of Education

171. Clinicians we interviewed believed education to be a critical component of any program to address operational stress injuries. This involves education at the front end of an individual's career and then periodically throughout one's career.
172. Dr. Peter Collins is a forensic psychiatrist with the Criminal Behaviour Analysis Unit of the OPP and is also the consultant forensic psychiatrist with the Royal Canadian Mounted Police. Dr. Collins is a part of the negotiation team of the Toronto Police Service Emergency Task Force. He told my investigators that any program addressing operational stress injury must start with education. Education, he said, helps to de-mystify the issue of operational stress injuries and decreases stigma.
173. An investigator also spoke with Dr. William McDermott, a widely respected clinical psychologist who has worked with police, fire and paramedic services, including Essex-Windsor and Waterloo Regional. Dr. McDermott told my investigator that education is a very important component of the prevention program for any emergency responder organization. This includes education at the recruit level and periodically throughout his or her career on topics such as wellness, resiliency, and stressors particular to their occupation.
174. The issue of education comes up repeatedly in the Mental Health Commission of Canada and the Public Services Health and Safety Association summary document, including making mental health and traumatic mental stress discussions "a normal part of job training", and to make training on the topic "mandatory" as part of the service's training curriculum.
175. The issue of education was featured prominently as part of the Ontario Ministry of Labour Roundtable on Traumatic Mental Stress where the idea of educating workers at all stages of their career on the risks, causes, symptoms, and preventative and ameliorating steps to address traumatic mental stress was discussed.
176. According to Dr. Ash Bender, staff psychiatrist and clinic head at the Work, Stress and Health Program at the Centre for Addiction and Mental Health, it is important to include topics such as coping, self-care and self-monitoring as part of education to first responders, as well as how and where to obtain assistance. As he explained to my investigator during his interview:

Given the nature of EMS work, often you can't necessarily predict or prevent exposures. But what you can influence is what happens after the exposure. Does it get reported? Are they adequately supported? Are they aware of treatment or others aware of treatment? That they recognize the need for treatment or intervention? And that's where the education and training becomes a really important aspect of it.

177. Another important aspect about education is improving "cultural communication" within the organization on the topic of operational stress injuries. An example of such education is the Road to Mental Readiness training developed by the Department of National Defence/Canadian Forces.
178. The training was designed to improve the resilience and mental health of members of the Canadian Forces on a short term and long term basis. The training is embedded throughout the career of the members, and is provided during periods of deployment as well as to the families of service personnel. Goals of the training include promoting mental health in the workplace and changing how members talk about mental health and mental illness.
179. Although developed by and for the Canadian Forces, the Mental Health Commission of Canada has adapted the training for police services and is piloting the program with services across Canada, including the Calgary Police Service and the Ottawa Police Service. According to the Commission, a preliminary evaluation of the training shows that it reduces stigma surrounding mental health and mental illness and increases resiliency.

8.3 Speaking with your Own – The Value of Peer Support

180. A theme that came up repeatedly throughout this investigation was the value of having a peer support team to reduce stigma and encourage members to seek help, with the assistance and/or guidance of a peer. Peer support is seen by many as a vital link for someone struggling with their own mental health, as well as an effective prevention strategy and an empowerment tool.
181. Dr. Elizabeth Donnelly, an interdisciplinary social researcher who has conducted extensive research on issues of mental health and first response services, including paramedics, told my investigator that, in her opinion, the peer support model for paramedics is "exciting" since it leverages a contextual reality that is already strong among paramedics: paramedics talking to paramedics.
182. In her experience, paramedics like to share a lot of "war stories" as a way to process some of their experiences. Creating a peer support model within this context, she feels, could potentially allow members to open up more:

There's a willingness, potentially, to talk to folks because they get it, you don't have to explain. You don't have to worry about traumatizing them further, which a lot of times happens with friends and family. If they're outside of it, they don't want to hear about the dead baby that you just saw.

183. One of the members of the Peer Resource Team echoed this sentiment during his interview with my investigators. One of the strengths of peer support, he felt, was being able to talk to someone else in the field who understands what it is like. "I've tried to describe (to a family member) in two hours what I described to (another paramedic) in literally three words – they don't get it."
184. The Mental Health Commission of Canada promotes peer support as an important contributor to recovery. Peer support is defined as a supportive relationship between two people who have a lived experience in common. The Commission has also developed guidelines for the practice and training of peer support programs.⁵⁴ It acknowledges that there is no "one size fits all" for a peer support program, and that it can take many forms, including being an informal or formal program.
185. Retired Staff Sergeant Brad McKay of the York Regional Police Service created the service's Peer Support Team in 2014 and is now assisting organizations, including first responders, to establish their own programs. Although some supporters of peer support programs advocate for members to be those with "lived experiences", S. Sgt. McKay believes that a long career as a first responder can allow someone to be an effective peer supporter. It is his belief that the opportunity to interact with a peer is "invaluable."
186. One of the more robust peer support programs for paramedics that we came across was that of Ambulance Victoria (Australia). The service, which employs approximately 3,700 staff, has a peer support program of over 150 volunteer peers that are managed by two full-time Peer Support Coordinators. In addition, four peer volunteers are rotated in each month to work as full-time peer responders to respond to potentially traumatic incidents in person. The program has four designated, marked cars for peer coordinators and full-time peer responders to reach stations in person. All peer supporters are appointed for two years, after which they must re-apply for the position.
187. The clinicians we spoke with stressed that peer supporters are just that - supporters. They are not therapists. We were told that it was of critical importance for any peer support team to have a mental health professional, preferably one versed in first responder culture, attached to the team to provide oversight and "maintenance" to the team in the form of training and support.

⁵⁴ Mental Health Commission "Guidelines for the Practice and Training of Peer Support" (2013) Online: <http://www.mentalhealthcommission.ca/English/document/18291/peer-support-guidelines>.

188. In the case of Superior North EMS, its peer support program has partnered with a clinician/researcher from Lakehead University. In addition to providing clinical support to the peer team, the clinician will be able to conduct research related to the program to assess its effectiveness and generate findings to share with other emergency medical service organizations.⁵⁵
189. The value of a peer support program can also extend to having peers talk openly about their experiences. It is believed that doing so promotes a change in attitude and assists in reducing the stigma associated with stress injuries.
190. The Canadian Forces has used a peer support model for years, referred to as the Operational Stress Injury Social Support (OSISS) program. The program consists of volunteers and paid employees and includes still serving members of the military and veterans who have operational stress injuries, as well as family members as peer supporters who have experience with operational stress injuries.
191. Retired Lt. Colonel Stéphane Grenier was involved in the establishment of the OSISS program as well as advancing mental health peer support across Canada with the Mental Health Commission of Canada. He has spoken publicly about the value of sharing personal experiences as part of education on mental health issues. Research has shown that real-life case examples provided by individuals that are viewed as credible can produce a strong effect on attitudinal change.⁵⁶
192. One of the chiefs with an Ontario paramedic service that we spoke with credited the openness of two of his paramedics about their struggles with increasing awareness and reducing the stigma associated with this issue:

These senior paramedics, 20 years plus of service, were highly respected by their colleagues and peers. They went off on stress leave and were off for some time...But what they did when they went off, not only did they leave, but they also openly talked about their experiences. And two things happened with that. First of all, people started saying 'Oh my God! These guys are (impacted by) this? So it lends credibility to it and acceptance. And the other thing is, if these guys, highly respected, trusted informal leaders in the workplace, if these guys were susceptible to this, and I've been doing the same thing for the past 15 or 20 years, what about me? And people started looking inward.

193. We were also told about an example from a member of the Peer Resource Team about the value in hearing from peers about their own experiences. He recalled one time in particular where a well-respected member spoke openly about his experience after dealing with a tragic call:

⁵⁵ Lucas Wimmer "Ontario EMS Agency Offers Program to Handle Workplace Stress" EMS World (11 June, 2015) Online: <http://www.emsworld.com/article/12082997/ontario-ems-agency-offers-program-to-handle-workplace-stress>.

⁵⁶ *Supra* note 4, p. 43.

He was really upset, he cried and he went and talked to (the staff psychologist) and he came back and he told everybody what he did. That really was very empowering to the staff. Wow, we don't need to hide it. We're all affected. We don't have to act so brave all the time. Which is great.

194. Some of the clinicians we spoke with mentioned the benefits of using peer support when an injured worker returns to work, to assist in the transition from injury to work, as well as addressing some of the stigma that comes with returning from a prolonged absence.

8.4 Family Matters – Education of Families about Operational Stress Injury

195. All of the clinicians that we spoke with stressed the importance of including the families of paramedics and emergency dispatchers as part of education and awareness on operational stress injuries. This might include events like a wellness session for families, and making information available on a website on supports and services to members and their families.
196. We spoke with Dr. Barb Anschuetz, a certified trauma psychotherapist and expert in traumatic stress. She is also the Clinical Director of the Trauma Centre in Sharon, ON, which provides treatment programs for individuals and their families, including many first responders. In her experience, the family of first responders are centrally impacted by issues related to operational stress.
197. What is important, she feels, is ensuring that members and their families have access to services and supports and know how to access them. She believes that this will help to address operational stress injury issues in the long run, "because if your family is falling apart, it's going to affect your ability to do your work. And if your work is falling apart, it's going to affect your ability to be effective in your family."
198. One of the chiefs of an Ontario emergency medical service told my investigators that the decision was made at his service to provide the families of members that were impacted by an operational stress injury access to an external psychologist, rather than have the family go through the general employee assistance program. Although this was an expensive option, this chief felt that it was a worthwhile investment to make in that it not only helped to alleviate the stress of the family but the stress of individual members trying to get assistance for his or her family.
199. As part of a redevelopment of its psychological support program, the Niagara Emergency Medical Services will offer education for spouses/families of

members on the impact of job-related stress and warning signs, as well as how to access assistance.⁵⁷

8.5 Understanding the Job – Employee Assistance Programs & First Responders

200. A common theme that emerged during our interviews with clinicians, paramedics, dispatchers, and management from emergency medical services was the need for clinicians and service providers to be familiar with the work of paramedics and dispatchers.
201. Some of the Ontario chiefs that we spoke with mentioned that the feedback they have received from members is that the EAP services available are fine for general stress associated with finances, child or elder care and marriage counselling. However, when it comes to addressing trauma issues associated with the job, there have been concerns expressed that EAP counsellors may not be adequate for paramedics.
202. One chief explained to us that the feedback he received was that "they don't get what I do, they don't know where I'm coming from." These members, he said, told him that they "would be much more comfortable speaking to somebody who knows where I'm coming from, whose been in my shoes."
203. One of the themes identified by participants in the forum put on by the Mental Health Commission of Canada and the Public Services Health and Safety Association was a need for service providers, including clinicians, to "have a deep understanding of the work environment" of first responders. In a recent survey of the mental health of paramedics across Canada conducted by the Paramedics Association of Canada, the feedback from the survey indicated that not only did those that responded want support services for psychological health and wellness, but they wished to obtain these services from a clinician that understands the role of a paramedic and what the job entails.⁵⁸
204. Counselling options offered to members of the New South Wales Ambulance include an external EAP, which offers specialized trauma counselling by trauma psychologists. The ambulance service has been proactive in providing training and support for the EAP practitioners so that they can better respond to the particular workplace stressors that impact paramedics.
205. Some first responder organizations in Ontario have attempted to improve the cultural literacy of external service providers. The OPP arranged for clinicians from its external service provider to receive specialized training about the

⁵⁷ *Supra* note 5 at p. 31.

⁵⁸ 77% of medics who completed the survey wanted access to health care professionals who understood para medicine. Paramedic Association of Canada "Health and Wellness survey" (undated: uploaded 7 August 2015) p. 34 Online: <http://www.paramedic.ca/document/2011/National%20Data.pdf>.

service's own internal programs as well as to increase awareness of police culture. My office was also told of a partnership established between an Ontario police service and the Ontario Psychological Association to create a one-day police competency session for psychologists interested in learning about policing culture.

206. Dr. McDermott offered us his opinion that any mental health professional retained by a paramedic service "absolutely" has to spend time with paramedics, spend time with dispatchers, ride on the trucks and spend time in the communications centre.
207. The first staff psychologist for TPS told us she needed to spend a lot of time riding out in ambulances and spending time in the dispatch centre, not only to learn the job of paramedics and dispatchers, but to establish her credibility.
208. During her interview with my investigators, the Deputy Chief for Program Development and Service Quality acknowledged the importance of external service providers having familiarity with the work of paramedics and dispatchers. She made reference to the fact that some of the service's non-uniformed employees face the same "request for credibility" amongst staff.
209. With regard to the City's EAP, my investigators were told that counsellors have varying levels of experience with supporting paramedics but that many of them have experience working with first responders, including working with the members of the Canadian Forces and police services. One of the counsellors has also been used at various times as the "back-up" for the staff psychologist and is currently assisting the service during a long term absence of the current staff psychologist. However, counsellors with EAP have not and do not do things like accompany paramedics on ride outs or spend time in the communications centre.

8.6 Knowing What You're Getting Into – Pre-Employment Screening

210. The idea that paramedics and dispatchers should receive some form of pre-employment psychological screening prior to being hired was raised by a number of individuals throughout this investigation in all parts of the TPS.
211. Some of the clinicians that we spoke with supported selection criteria based on psychological grounds, such as excluding applicants that demonstrate lower resiliency traits or who were otherwise unstable from an emotional/psychological level to engage in the type of work done by paramedics and dispatchers. Other clinicians felt that that screening tools, like the Minnesota Multiphasic Personality Inventory (MMPI), were not very useful and could be skewed by the manner in which the test is administered.

212. The Toronto Police Service, like other police services across Ontario, use the MMPI to screen out psychopathology that would interfere with the bona fide responsibilities of the role, as well as screen in applicants with traits such as empathy, resiliency, positive coping styles and strong personal resources. This process, however, does not screen for mental health issues in general, like depression and anxiety.
213. Some individuals that we spoke with said the Ontario colleges of applied arts and technology that offer a paramedic program need to have selection criteria for students that would, hopefully, ensure students that are admitted into the program are aware of the risks associated with a career as a paramedic. This was also raised as a concern by participants in the Ministry of Labour's Roundtable on Traumatic Mental Stress.⁵⁹
214. A retired chief from TPS told us during his interview that, in his opinion, the onus is squarely on the colleges, "so that not only are people going to be successful in the community college program, but within their first year of employment they're not going to fall into difficulties because of this whole issue of PTSD." He noted that, in his experience, there are "too many horror stories" of paramedics that have successfully completed the college program and after their first or second traumatic call, "that's when they find out they're not cut out for it."
215. Another chief of an Ontario paramedic service agreed with this assessment, noting that the industry as a whole does not do an adequate job of pre-employment education at the college level. He believes there needs to be a greater emphasis on mental health and wellness prior to a paramedic starting their career with a service.
216. Our review of the paramedic programs offered in Ontario colleges found that some of the programs included topics such as trauma, crisis response, and responding to and coping with the psychological and emotional components of being a paramedic.
217. TPS currently does not use any form of pre-employment psychological screening. Documents that we obtained from the service indicate that it has considered implementing some form of pre-employment screening that involves screening for psychological issues and selecting applicants that are viewed as "optimal" for employment in the field, focusing on ideal characteristics, personality, motivations, etc.
218. The Paramedics Association of Canada advised my investigator it has identified pre-employment screening as an area the industry should be exploring. Among other paramedic services, my investigators discovered that the paramedic service in Regina-Qu'Appelle Health Region previously used the MMPI with

⁵⁹ *Supra* note 47 at p. 13. One of the suggestions is to "Market jobs realistically in schools and in general, to ensure recruits and young people are aware of the risks that they may face in certain occupations."

applicants, although this is no longer done. Ambulance Victoria is in the process of introducing psychological screening for paramedic applicants.

219. Within Ontario, the Ottawa Paramedic Service appears to be the only paramedic service that has implemented a psychological screening process for applicants. Currently being applied to dispatcher applicants and will be used in the next round of hiring for paramedics, the process involves a standardized test and interview with an external psychologist to assess applicants for their suitability as well as assessing the resiliency of the individual. At the conclusion, the only information provided to the service is a Yes, No, or Maybe.

8.7 Responding to the Responder – Providing Assistance to Paramedics and Dispatchers

220. One of the aspects of proactive intervention is identifying when a member may have been involved in a critical incident or when a member is showing signs that are consistent with experiencing critical incident stress. Closely connected to this is the consequent accessibility of those interventions.
221. Dr. Bender stressed in his interview that an integral component of responding in the aftermath of a potentially traumatic incident is recognizing that a member may have been hurt or injured as a result of his or her involvement. A failure to acknowledge this can lead to members feeling neglected and resentful of their employer for failing to recognize the impact the incident had.
222. Some of the organizations that we contacted have established notification protocols to be used when it is believed that a member or members may be in need of support. New South Wales Ambulance created a staff support activation procedure that lays out a range of issues that could cause a member distress and includes potential pathways of support. All potentially traumatic incidents are flagged by frontline managers at the scene. Depending on the severity of the incident, staff may attend sessions with a trauma psychologist or receive an informal welfare check from their supervisor.
223. Ambulance Victoria has a protocol that involves dispatch notifying the peer support coordinators to orchestrate a response. Additionally, the peer coordinators receive an automated report of potential traumatic incidents from the electronic ambulance incident logs of calls from the previous day for follow up by peer supporters.
224. At the London (U.K.) Ambulance Service, frontline supervisors are to notify the service's Staff Support, Counselling and Occupational Health Services Unit of any traumatic incidents. The service's in-house psychiatrist will then conduct a mandatory one-on-one risk management interview with all involved members 72 hours to one week after the incident. The interview includes an educational session and is also a risk assessment tool to determine whether specialized

- treatment is required. A follow up session is conducted four to six weeks after the incident.
225. The Toronto Police Service has a Critical Incident Policy that includes details on notification for the service's Critical Incident Response Team and the Peer Support Volunteer program. Supports offered by the service include debriefings, defusings, and, when required, arranging for professional assistance.
 226. Although the policy affords the officer-in-charge discretion in assessing and determining the appropriate level of support for members, the policy lists factors to consider when conducting this assessment and notes that a decision should be made by taking into account the nature and circumstances of the event, rather than the reactions or lack of reactions, of the individuals involved. The policy notes, however, that any time a member requests any of the above services, the supervisor is required to initiate the notification.
 227. At present, the method for activating supports within TPS is left to the discretion of the superintendent, based in part on feedback obtained from paramedics, as well as the duty officer. Unlike the Toronto Police Service, there is no formal policy or guideline offered to superintendents or duty officers to assist them in determining when to activate supports for members.
 228. We spoke with a clinician who was involved in responding to critical incidents for a paramedic service. He stated that the call in procedure was "ad hoc" and "more haphazard than it should have been" because it was not properly codified in a procedure. Although supervisors knew that the clinician could be called out to respond to a critical incident, there were no criteria defining critical incidents requiring support. Activation of supports in the aftermath of a critical incident, he believed, needed to be organized and codified within a service.
 229. One of the concerns that we heard about was that, in the absence of a formal notification protocol, decisions as to whether to activate support mechanisms may get lost in the shuffle of competing operational demands. Others also commented on the potential for such decisions to be dependent on who happens to be the supervisor that day, or who is sitting as the duty officer.
 230. The British Columbia Ambulance Service has a peer critical incident stress team that is to be activated to respond to members that have been involved in potentially traumatic calls. However, my investigator was advised that there is no formal procedure that guides this notification process. The result, we were told, is that the team is missing a lot of potentially traumatic events, limiting the ability for the team to respond to employees that may have been impacted.
 231. In terms of the provision of psychological services, we found some services that provided these services directly to members. The London Ambulance Service, for example, has an in-house psychologist that provides counselling directly to

the service's approximately 4,500 staff. The service also contracts out counselling services to five external counsellors that have been interviewed and vetted for their skills in trauma counselling and their familiarity with first responders. The service covers all the costs associated with the treatment, which initially consists of six sessions with the option of extension.

232. With Ambulance Victoria, counselling for paramedics is provided by 85 contracted psychologists across the state. The service, offered as both short-term and long-term, is free for paramedics and their families. Members are also able to self-refer to a psychologist through a 24/7 phone line.
233. Clinicians that we spoke with noted that, while laudable, there are complications with having a mental health professional directly on staff to provide psychological services to members. Members tend to be suspicious of a clinician who works for the organization, with concerns over confidentiality, privacy, and what is done with the information gathered by the clinician.
234. Organizational clarity on the role and function of the internal mental health professional can help to address this issue. The first staff psychologist for the TPS told us that, in her experience, it was essential for everyone in the organization to know what her responsibilities were and what information, if any, was shared within the organization in order to establish trust and confidence in the services provided.
235. Another issue that emerged was the physical location of services. If the psychologist's office is located at a main building for the organization, this could serve as a deterrent. As one clinician expressed, members who wish to voluntarily reach out to an in-house psychologist but are required to attend headquarters may be reluctant to do so "because they don't have any confidentiality when they are coming and going. Sure, they have confidentiality regarding the content but they don't want to be seen coming and going from Dr. Bonkers' office."
236. Dr. Carleton explained that the physical location of psychological services can be a very significant aspect of accessing assistance, especially when stigma is factored in. Whereas 30 years from now, there may no longer be a stigma attached visiting a psychologist's office, that is not necessarily the situation today. Having access to a location off-site, he believed, would help preserve member confidentiality.
237. The Psychological Services Division of the Calgary Police Service, which provides psychological services to members directly through in-house psychologists and externally through a network of psychologists and social workers, is located off-site from headquarters. A clinician for the Calgary Police Service described the psychological services provided to members as allowing for "geographic confidentiality." The Peer Support Team office for the York

Regional Police Service, previously located at headquarters, is now located off site in a building with no external service markings.

238. Within Ontario, although TPS is the only paramedic service with a psychologist on staff, there are some services that have established relationships with external clinicians for the purposes of providing members with support.
239. One of the services that we spoke with has a history of external psychologists with experience in the first responder environment on retainer to provide counselling for members. The service has a referral mechanism in place and the total cost for the psychologist's services is covered by the service.
240. Two other services that we spoke with advised that they have established "ad hoc" mechanisms in place to get members psychological assistance from local hospitals or clinicians if that need is identified. Both of these services advised us that, typically, these mechanisms are accessed when it is felt that the external EAP was an inappropriate referral for the member.

8.8 One is Too Many – Paramedic Suicide

241. Death by suicide is a tragedy that impacts individuals from all walks of life and contributes to a significant number of premature and preventable deaths in Canada. In 2009, Statistics Canada reported that there were 3,890 suicides in Canada for a rate of 11.5 per 100,000 people, making suicide one of the leading causes of death for all ages. It is also estimated that for every completed suicide, there are as many as 20 suicide attempts.⁶⁰ The Canadian Association for Suicide Prevention estimates that for every suicide, seven to 10 survivors are "profoundly affected."⁶¹
242. The issue of suicide within first responder industries, such as military, police, fire and paramedic, as well as correctional officers, has been raised, with increasing alarm, in recent years.
243. The Tema Conter Memorial Trust is an organization dedicated to raising awareness and providing support and training on the issue of operational stress and post-traumatic stress disorder amongst first responders. It has reported that in 2015, across Canada, there have been 30 first responder suicides and eight Canadian Forces suicides to date. In 2014, from April 29 to December 31, there were 27 first responder deaths by suicide, and 19 Canadian Forces suicides in 2014.⁶²

⁶⁰ Tanya Navaneelan, "Suicide Rates: an Overview" (7 /25/2012) Statistics Canada Catalogue [82-624-X] Online: <http://www.statcan.gc.ca/pub/82-624-x/2012001/article/11696-eng.htm#cvsd>.

⁶¹ The Canadian Association for Suicide Prevention. "What is Suicide: Suicide in Canada" online: <http://suicideprevention.ca/understanding/what-is-suicide/>.

⁶² Tema Conter Number of Canadian first responders' death by suicide "Update" on homepage, online: <http://www.tema.ca/#!/home/c1qd9>.

	2014	2015
Correctional Officers	5	3
Fire Fighters	3	8
Paramedics	5	11
Police Officers	14	8
Total	27	30

244. Death by suicide among paramedics is an issue that has impacted services across Canada, including Newfoundland and Labrador,⁶³ New Brunswick,⁶⁴ Saskatchewan,⁶⁵ and Alberta.⁶⁶ In the latter case, the 2015 suicide of paramedic Greg Turner prompted the creation of a task force to establish recommendations to improve mental health services for first responders in that province.
245. Investigators spoke with the President of the Paramedic Association of Canada about a Mental Health Wellness Survey that the association recently conducted of paramedics across Canada. The survey, although not scientific in nature, received approximately 6,000 responses from paramedics, including some dispatchers and paramedic supervisors. Out of approximately 6,000 responses, about 2,100 (or 35 percent) were from Ontario.
246. The President reported that he was "shocked" by the survey responses associated with paramedics and suicide. Looking at the numbers for Ontario, just over 27 percent of respondents indicated that they had contemplated suicide, while almost 63 percent responded that they knew of a paramedic that had contemplated suicide. Almost 70 percent of respondents indicated that they had at one time been concerned that a paramedic might be at risk for suicide, whether or not that paramedic had admitted to thoughts of suicide.
247. Among those we interviewed, there was a mixed reaction to the issue of first responder suicide.
248. Although everyone agreed that the death of a colleague by suicide was tragic, some felt that too much attention was being placed on the number of deaths by suicide without putting it into a broader context. One chief that we spoke with took issue with the way the media reports on paramedic/first responder suicides, believing that the media was "sensationalizing" the topic. Another chief acknowledged that there have been suicides of paramedics, but the cause of death should not automatically be assumed to be "because of the job."

⁶³ Jeff Cottrill "Union calls for better mental-health supports following paramedic's suicide: Newfoundland and Labrador Association of Public Employees president speaks out." OHS: Occupational Health & Safety Magazine (18 August 2015) online:

⁶⁴ "First responders struggle with PTSD" CBC News (New Brunswick): (10 March 2014) online: <http://www.cbc.ca/news/canada/new-brunswick/first-responders-struggle-with-ptsd-1.2566363>.

⁶⁵ Rachel Bergen "Family of Saskatchewan paramedic speaks out on depression" CBC News (Saskatchewan): (6 April 2015) online: <http://www.cbc.ca/news/canada/saskatchewan/family-of-saskatchewan-paramedic-speaks-out-on-depression-1.3022406>.

⁶⁶ Pamela Roth, "Paramedic suicide leads to mental health task force in Alberta" Edmonton Sun: (9 February 2015) online: <http://www.edmontonsun.com/2015/02/09/paramedic-suicide-leads-to-mental-health-task-force-in-alberta>.

249. One of the chiefs that we spoke with took another view. He believed that it was incumbent on the industry to adjust how member suicides are viewed. Instead of engaging in debates about the cause of the death, he said, the industry as a whole should focus on how to improve outcomes. He said:

The fact is that I think that until we're challenging really needing a definitive cause, that that's part of the struggle that we're having as an organization and as a profession in, well, how do we change how we approach this? How do we change the conversation?...Because the predictable nature of such an extreme choice is you'll never know. So unless you change the way you look at the problem, you'll never come up with a different answer.

250. It has been noted that the presence of mental illness is the most important factor when assessing for risk of suicide, with research showing that more than 90 percent of people who complete suicide have a mental health issue or addictive disorder.⁶⁷ Dr. Bender told us that suicide is "almost nearly always" associated with a psychological condition, often depression. Suicide, he explained, is "multi-causal" and, other than determining the cause of death, one will not be able to fully determine the reasons for the death.
251. Dr. Bender believes that focusing on the causal factors and the inability to determine the cause of a suicide should not prevent an organization from establishing a suicide prevention strategy. Incorporating a suicide prevention strategy within any workplace is essential, he believes, not only because it could save someone's life, but because the organizational impact of a suicide is devastating and far reaching. For first responder organizations, which is a group that is potentially at higher risk for mental health issues, Dr. Bender believes that creating a suicide prevention strategy is an opportunity to take initiative and potentially save lives.
252. An example of this is the Toronto Fire Services, which has implemented a suicide prevention program in coordination with the Centre for Addiction and Mental Health. This program includes a phone line for immediate no-referral admission into the Centre's emergency department. The service covers the cost for the first few sessions of counselling, with additional sessions covered by the employee's benefits. The program is confidential and the service is currently negotiating with the Centre for Addiction and Mental Health to establish it as a permanent program.
253. We heard from clinicians that even if the number of reported suicides with an organization is low, this should not preclude the establishment of a suicide prevention program, which should include education. Dr. Collins advised that education is important in terms of raising awareness about the signs and

⁶⁷ *Supra* note 59.

symptoms associated with suicidal behaviour. Dr. Anschuetz advised that organizations should not wait until tragedy strikes, noting that a proactive approach to the issue could result in saving a life.

254. In our interviews with chiefs of paramedic services across Ontario, although none of them were aware of any completed suicides within their services, some of them were aware of attempted suicides.
255. One chief described how the attempted suicide by one of the more respected members of his service "shook us to the ground" and gave him pause to consider what supports his service was offering and whether it was sufficient. He found there were gaps in terms of the availability of psychological support through member benefit programs, with limitations on accessing the services of a psychologist. This was subsequently amended to allow members to use their benefits to pay for psychological services.
256. The current staff psychologist for TPS believes that suicide is a greater concern amongst paramedics than it is with other first responders. In her experience, paramedics that attempt to complete suicide select a means that has a greater likelihood of lethality. She believes that greater attention should be placed on suicide education and awareness for paramedics.
257. The staff psychologist shared with us a situation where she spoke with the spouse of a member who presented suicidal ideation. The staff psychologist told the spouse about certain items to be aware of that could be used to attempt suicide, such as medication kits, vials, needles, etc. She recalled that, after providing this information, the spouse broke down. The spouse explained that these items had been in the house for some time now, but had believed they were for family use for first aid purposes. "(The spouse) had no clue that those items that appear to be for medical use have the potential to be so lethal for that individual."

8.9 Honouring the Fallen – Death by Suicide

258. The issue of honouring a first responder that has died by suicide is a complicated and contentious one.
259. The death by suicide of retired Toronto Police Service Staff Sgt. Eddie Adamson and the discussion surrounding whether his name should be included on Ontario and Toronto police memorials is an example of the sensitivity and complexities surrounding the topic.⁶⁸ We were advised that the spouses of some of the officers killed in the line of duty have threatened to take their spouse's names off memorials if the names of members that have died by suicide are included.

⁶⁸ Adrian Humphreys "Officer who killed himself after tragic rescue attempt denied spot on police memorial" *The National Post* (7 October 2012) online: <http://news.nationalpost.com/news/canada/officer-who-killed-himself-after-tragic-rescue-attempt-denied-spot-on-police-memorial>.

260. Dr. McDermott told us that he is a passionate supporter of offering the families of all first responders that have died by suicide the opportunity for the death to be treated like any other line of duty death. Doing so, he believes, would take away the stigma associated with suicide and ensures that, for example, a paramedic is honoured as one.
261. One of the Ontario chiefs that we spoke with advised that, typically, how a service chooses to approach sharing information about and honouring a paramedic that has died by suicide is determined by the wishes of the family. However, he felt the fact that there has not been a formal line of duty death ceremony for a paramedic that has died by suicide is problematic. This, he felt, would do much to change the views and attitudes towards death by suicide.

I think that's one of the challenges: there's never been a line of duty death funeral for a member who has taken their life. In my mind, that ceremony would bring so much recognition and validation to the silent crisis. I think that would change the way that we really think and approach responder suicide. And that hasn't happened yet.

You hope that it doesn't take that, but I think that more and more when you look at celebrating a line of duty death with an appropriate ceremony, with a member whose taken their own life, that would be something that would certainly change the landscape in terms of recognition and eliminating stigma and really bringing awareness that this is something that we all need to ensure organizations are focused on, recognizing it within their staff.

9.0 Analysis and Findings

262. The staff psychologist is one of the main components of the psychological services program. One of the Peer Resource Team members described the role as the "central hub" for all things psychological within the service.
263. Throughout the investigation, we heard a variety of views about the value of having a full-time staff psychologist.
264. From paramedics and dispatchers, we heard that the ability to speak with and obtain short term counselling from an in-house psychologist that "gets" what they do was, and continues to be, of great importance.
265. This was reaffirmed by members of the Peer Resource Team, with many believing that the ability of the staff psychologist to connect was critical to making members more comfortable in coming forward. One peer member told us that the staff psychologist "had the knack of breaking down barriers", while another believed that being able to speak with a psychologist who understood what they did contributed to decreasing stigma and encouraged members to come forward.

266. Within management, there was a greater variety of views on the value of a full-time staff psychologist.
267. Some believed that for a service as large as the TPS, it was important to have a staff psychologist to look after the psychological health and well-being of the staff. Others felt the role was better suited as an external one. Some managers felt that the service needed to have more than one psychologist on staff, with a greater focus on overseeing and managing psychological supports and services within TPS, while using an external referral network for counselling needs of paramedics and dispatchers. Others conceded that, even after all these years, they remained uncertain about what the exact purpose of having a staff psychologist.
268. One of the Deputy Chiefs stated that the distinction of being the only paramedic service in Canada to have a psychologist was "a plus and a minus." He believed that, even after almost 30 years of having one, it was an area that the service "really needs to work on."
269. The question of whether it is worthwhile for TPS to employ a full-time staff psychologist has been raised.
270. As part of a 2004 Operational Support Review of TPS, the Auditor General reviewed the position of the staff psychologist. The review noted that the psychologist did not have an annual work plan and did not track any workload statistics. "As a result" the Auditor General wrote, "we are unable to reasonably assess whether it is cost effective to have a full-time, designated position in EMS."⁶⁹
271. The Auditor General recommended that TPS review the current services provided by the staff psychologist and assess the costs of the services and the availability of such services through the City of Toronto's benefit plans. In support of this, the Auditor pointed to the fact that employees could access EAP as well as the availability of \$300 per person per benefit year for psychological services.
272. In response, TPS defended the position, pointing out the "limited level" of psychological services coverage to which employees had access. The response also noted that Human Resources indicated it would be "more costly" to outsource the role of the staff psychologist. TPS also wrote that an external psychologist "would not address the need for a psychologist with the background and expertise in working with staff in emergency medical care roles."

⁶⁹ City of Toronto Auditor General, "Staff report: Toronto Emergency Medical Services Operational Support Review – Works and Emergency Services Department" presented to Audit Committee (29 November 2004) p. 22.

273. With respect to EAP's ability to provide support, the response said that Human Resources did "not feel it is a feasible option." It pointed out that at one time EAP assisted the staff psychologist in conducting debriefing sessions but had to withdraw due to its own "limited resources." Noting the increased referral demand from other areas of the City, EAP also advised that there was little chance they could offer 24/7 service, in contrast to the staff psychologist.
274. The current Chief told my investigators he believed that having a full time staff psychologist was a great thing for the service, in particular, for the guidance and expertise that the position offers the service. The Chief noted that the issue of whether the TPS should even have a full-time staff psychologist has also come up during his tenure as Chief:

There was a lot of pressure in the organization with core service review and all of the things that were coming up, budget issues, and we were being asked to cut 10 percent from our budget. Actually, (the staff psychologist) position came up three times in three different budgets. You know, you're the only organization that has a staff psychologist; why can't you contract this out? And we defended (the) position, and rightly so. I wanted to have an expert in the organization.

275. With the departure of the second staff psychologist and the hiring of the current one, there was a desire within TPS to raise the profile of psychological services, to establish it as more than just the staff psychologist and have it as part of a broader, comprehensive program for TPS. However, the situation has not unfolded as anticipated. The Chief remarked:

I think we envisioned the psychological services/wellness program as being sort of a comprehensive program, similar to many of the other programs that we have in the organization. And I don't think we have a comprehensive program here.

9.1 Creating a Psychological Health and Wellness Plan

276. TPS is properly recognized as a leader in the psychological services field for first responders and has been for decades. We heard multiple times that the service is leading the way in a field that has no road map.
277. It is evident that TPS does have in place the elements of a comprehensive psychological services program. However, it has not developed a comprehensive coordination of the elements that comprise its psychological services program.
278. TPS is not immune from the societal stigma associated with mental illness. This stigma permeates most of our organizations and communities. In first responder,

para-military and military institutions, the stigma is exponentially more pervasive with the added attitude of "suck it up."

279. This reality, coupled with the challenging work of TPS members, renders the obligation for TPS to continue to be a leader.
280. It is for these reasons, along with the evidence gathered in this investigation, that I am making a number of recommendations about organizational structure with respect to the placement and role of psychological services.
281. Further, I have made recommendations to improve processes, create new policy, address confidentiality, provision of trends data, delivery of education and the implementation of pre-employment screening.

9.2 The Role of the Staff Psychologist – Providing Clarity

282. There is no reference in any policy or procedure to the role and mandate of the staff psychologist.
283. It is evident that, with the departure of the second staff psychologist, TPS wished to change the role and restructure the psychological services program. We were told there was much discussion about the desired change in direction, but we found no documents to that effect.
284. In comparing the two job profiles for the position of staff psychologist, one from 2003 and the other from 2010, the major responsibilities of the position are, with one exception, identical. That exception is a responsibility for the staff psychologist to provide "confidential service reports to identify trends and make recommendations to address personnel and organizational needs."
285. The 2003 and 2010 job profiles speak generally to the duties of the position, including: developing plans and policies; conducting research; providing short-term counselling and psychological intervention for staff after traumatic events; availability 24 hours a day, seven days a week to attend to staff personal crises; providing wellness training and; selecting, training and supervising a peer team.
286. During his interview with my investigators, the Chief stated that for a service the size of Toronto that deals with such a high call volume, having one staff psychologist was "not really an achievable or successful solution." He thought the position should focus less on individual counselling and more on developing and managing a comprehensive psychological services program.
287. One of the Commanders that we interviewed agreed with this assessment. Although he believed there was tremendous value in the counselling service, he felt that it was too much responsibility placed on one person. "If we could have had five (staff psychologists), I don't think we'd be sitting here having this

discussion" he told my investigators. He thought it was necessary to have the position look after the "administration" of psychological services with a robust network of external clinicians.

288. Victoria Ambulance offers an example of a large paramedic service that employs a psychologist who is responsible for managing the Victorian Ambulance Counselling Unit but does not provide any direct counselling to staff. The model includes an external network of 85 clinicians, including psychologists, across the State, that staff can access for short or long-term counselling, all of which is paid for by the ambulance service. The service's psychologist oversees the contracts with the external clinicians.
289. The TPS staff psychologist acknowledged that there was a high demand for service. Short-term counselling for members generally consisted of a few consecutive sessions to help that member "bounce back." In some cases, after a preliminary assessment, the staff psychologist would offer the member an external referral, either to EAP if the issue was more generalized, or to a community service provider. Clinicians with experience dealing with first responders are part of an external referral network that the staff psychologist established.
290. For her part, the staff psychologist told my investigators that acting more as an overseer of psychological services, rather than a counsellor, was certainly an option and in fact could help to clarify the role within the service. She remarked on the challenges members face in accessing psychological supports within the community, largely on account of the limited funding available for members in their benefits plan. She felt that "gaps" such as this would need to be addressed to ensure the success of the transition of the role from counsellor to strategic program manager.
291. It seems to me that TPS should clearly communicate the role of the staff psychologist more broadly, including in the context of the services' larger psychological health and wellness plan. (Recommendation 2)
292. As part of the above, TPS should keep in mind the need for employees to access a clinician or clinicians that are intimately familiar with the psychological stressors unique to the service. (Recommendation 3)
293. In addition, I would like to comment on the 2004 audit of the staff psychologist's position by the Auditor General. I believe that it is a valuable insight into the complexities of measuring the value of such a position.
294. The Auditor was correct to note the need for tracking statistical trends. These are important data for the organization to review, understand and act on accordingly. They also inform the nature and resources required for the program

and, in the final analysis, they can justify the costs and efficacy of the service provided.

295. The suggestion that members had access to EAP and psychological benefits fails to consider the challenges faced by members dealing with operational stress injuries.
296. Social metrics remain quite new as a measure of success in evaluating fairness and equity. While the auditing function is critical to all public organizations, I would caution against using the metrics of financial measurement as the sole way of assessing a program's success. The "bottom line" does not take into account social costs or achieving equity. Measuring fairness is not simply an exercise in achieving bottom line efficiencies and saving money.

9.3 The City EAP – "Request for Credibility"

297. In terms of the usefulness of the services offered by EAP, my office received mixed reviews from the paramedics and dispatchers that contacted us. While some felt that they had been provided with good service, others had the opposite experience, believing that it was not helpful.
298. Some indicated that they did not have any confidence in accessing services from EAP, citing issues of confidentiality or the qualifications of the counsellors. Others commented they were not familiar with the services provided by EAP.
299. The EAP has, in the past, conducted satisfaction surveys of its services, although we were told by a counsellor that such surveys are fraught with "response bias." The TPS, as an organization, does not solicit any feedback from staff about their satisfaction with services provided by EAP.
300. In terms of number of contacts, since 2010, EAP has provided 386 services to TPS employees and their families, 88 of which were noted as being related to work or 'mental health.' The staff psychologist in 2012 alone received approximately 430 first time calls for support.⁷⁰
301. The staff psychologist is currently away on a long-term leave. In her absence, the service has relied on a counsellor from EAP to provide coverage for services such as consulting with members of the Peer Resource Team and providing some training to peer members and management. EAP, however, does not provide on-call coverage.⁷¹ A counsellor at EAP commented that, unlike the staff psychologist, EAP is unable to offer a full-time staff member to specialize specifically in services for TPS members.

⁷⁰ Op. Cit., p. 31.

⁷¹ January 22, 2013 email from City EAP to TPS Staff Psychologist.

302. My investigators were advised that, during the tenure of the second staff psychologist, EAP would attend TPS occasionally through the year to events like a wellness day for members and their families, as well as meet with members of the Peer Support Team. The purpose of such visits was to provide information on the services from EAP and sometimes to facilitate workshops on wellness related issues.
303. Some of the Peer Resource Team members told my investigator that, in the absence of the staff psychologist, they appreciated a closer relationship with EAP and believed that the services offered were helpful for members. Some felt those services could have been "pulled in" a little sooner, prior to the staff psychologist going on leave.
304. Many Peer Resource Team members, however, commented that paramedics on the road or dispatchers in the communications centre did not feel comfortable contacting EAP because of the perceived lack of familiarity with their occupation. Team members also commented on their own reservations in referring members to EAP, given the belief that counsellors did not understand the paramedic and dispatcher role. One Peer Resource Team member commented:

I can suggest to them to go see the EAP person for the City, but again, they're not dealing with somebody that knows what's involved in dealing with the death of a young person (for example). They're qualified, but it's not the same as having a staff psychologist. They don't understand what a paramedic sees or an EMD has to listen to during a crisis. It's not ideal. They've been helpful for people that are having personal problems outside the job, they've been insightful and provided support like that. But for direct stress calls and PTSD stuff, it's really not their expertise.

305. It appears to me that EAP is facing the same "request for credibility" from members of TPS that non-uniformed members of the service have experienced. Evidence gathered by my investigators suggests that members do not feel that EAP understands the unique stressors and nature of their job. This is despite the fact that at least some EAP counsellors have experience providing services to first responders.
306. Similar to the arrangement used by other services that rely on EAP, such as New South Wales Ambulance, I believe that it would be beneficial if counsellors at EAP were to become better aware of the operational culture and unique psychological stressors of paramedics and dispatchers. This might include counsellors going on ride outs with paramedics, sitting in on calls with dispatchers at the communications centre, and attending Continuing Medical Education sessions.
307. I am cognizant of the fact that EAP is responsible for providing services to the entire Toronto Public Service and its families. I also understand that resources

are thin. However, if TPS is going to rely on EAP as a primary component of its psychological support program, then it is incumbent on TPS and EAP to ensure that the resource is as effective as it can be. (Recommendation 4)

9.4 Benefits for Psychological Services – How low can you go?

308. Improving the relationship between TPS and EAP for the purposes of providing short-term counselling takes on greater importance when considering the benefit for use of a psychologist is only \$300 per person per benefit year.
309. There was unanimous agreement from all interviewees that \$300 coverage was, in the words of one counsellor, "abysmally low." Staff from Human Resources acknowledged that the \$300 limit was low. We were told that a treatment such as cognitive behavioural therapy for PTSD or depression may take up to 10 sessions; \$300 coverage would only cover the cost of the assessment.
310. One of the clinicians described the amount of coverage offered for psychological services for Toronto paramedics and dispatchers as an "insult" and a "joke", especially in light of the fact that members of the Toronto Police Services receive \$3,500 in coverage for psychological services, while members of the Toronto Fire Services receive \$1,000 coverage. "They don't care that they get a lot of massage treatment funds," she told us, "They want to be able to deal with the psychologist."
311. The staff psychologist commented to my investigators that she has "run out of favours" with colleagues in the field to get around the low benefits coverage for psychological services. "I'm constantly asking favours, can you just see them even though they don't have the coverage? Please. I don't have favours left to get paramedics care."
312. One of the Ontario chiefs that we spoke with shared his concerns about the constraints put on his service to assist paramedics due to limits in benefits for psychological services. "There may be a cap on how much counselling service might be available to an employee, corporately, through collective agreement benefit entitlements", he noted, "but frankly, my view is that's very short sighted, at least when it comes to employees who have a higher pre-disposition to occupational acquired stress injuries."
313. Of course, the alarmingly low benefits coverage for psychological services is not specific to the TPS, but is rather a City-wide issue. I also understand that collective bargaining properly reflects the needs of the majority. But the challenges faced by paramedics and dispatchers place them in a unique situation, along with police and fire, relative to the rest of the public service.
314. It would be appropriate for the employer and the union to review the benefits coverage for psychological services for paramedics and dispatchers. Ensuring

that these members of the public service have access to appropriate care is a health and safety issue. And it cries for attention.

315. For its part, TPS has already developed helpful initiatives to assist members in obtaining psychological assistance from external resources. There is an external referral list of clinicians that have experience treating and supporting first responders. The service is also in the process of creating a 24/7 hotline that members can access for immediate access to clinicians, although members will have to cover the cost of these services themselves.
316. The TPS can build on its positive initiatives. Consistent with suggestions made to my office, TPS could engage with organizations like the Ontario Psychological Association to create a system to allow members to use their psychological benefits for the purpose of obtaining a mental health 'check-up.'
(Recommendation 5)
317. The concept of an annual mental health check-up is one that we heard could normalize and reduce the stigma associated with proactively accessing psychological services. Ambulance Victoria, for example, offers members voluntary annual one-on-one appointments with a psychologist.
318. Referred to as Stress Management and Resiliency Tools, members complete a questionnaire designed to identify early signs of conditions such as depression, anxiety and trauma, and then discuss the results with a psychologist. The psychologist can either offer a treatment plan or provide the member with coping mechanisms. Aside from identifying issues early, the program is meant to normalize recurring checkups with psychologists, similar to an annual physical with a doctor.

9.5 Notification and Activation of Psychological Supports

319. Soon after commencing her position, the current staff psychologist conducted a service-wide assessment, surveying all paramedics and dispatchers anonymously through the annual Continuing Medical Education program.
320. The results of the survey indicated that an overwhelming majority of TPS members (91 percent of paramedics and 92 percent of dispatchers) were supportive of moving to a proactive model of psychological care. This model included the implementation of 'courtesy checks', where, following incidents of elevated risk for potential psychological impact, a non-intrusive point of contact is made to a member via cell phone or pager to offer one-on-one support.
321. In addition, based on survey feedback, the staff psychologist developed a guideline for proceeding with courtesy checks. It incorporated incidents that were typically associated with elevated distress for paramedics and dispatchers,

such as large-scale multiple casualty incidents, death of a colleague, and incidents involving vulnerable groups (e.g. the death or abuse of a child).

322. The staff psychologist identified the need to have "more consistent incident identification", including the creation of a standard operating procedure, to allow for the timely notification of incidents to enable support, either by the Peer Resource Team or the staff psychologist.
323. We examined documents where the creation of a notification protocol was discussed. One document prepared by a Deputy Chief said the issue of 24/7 availability of the staff psychologist does not reflect the expectations of the services to be provided by the psychologist.⁷²
324. The service agreed to create a "communication document" to address various issues associated with the 24/7 issue, including the development of a "specific algorithmic protocol for 'after hours' responses" to critical incidents, 'critical' being defined as arising out of an extraordinary event not normally encountered in the line of duty for a paramedic or dispatcher. It is our understanding that no such protocol was developed.
325. Other documents provided by TPS indicate that attempts were made to establish a formal notification protocol for the purposes of facilitating contact with the staff psychologist or Peer Resource Team. However, nothing was developed.
326. Although not a formal protocol, in July 2015, TPS gave staff Critical Incident Stress Strategy pocket reference cards. They listed "red flags" that may occur due to critical incident stress and encouraged members to seek assistance from sources such as the Peer Resource Team, EAP and others if they were experiencing any of the flags, noting that early intervention was key to obtaining assistance.⁷³
327. Another pocket reference card was also developed for superintendents. It outlines the value for supervisors to "check in" with a paramedic after a stressful call, although it is noted that what may constitute a critical incident differs from person to person. The card stresses the importance for supervisors to listen to members without making assumptions; lists red flags immediately following and two days post-incident; and suggestions for offering support, such as referring to the Peer Resource Team or the staff psychologist.

⁷² The 2010 job profile for the Staff Psychologist position includes "Maintains availability twenty-four hours a day, seven days a week to attend to staff personal crises, and attends to staff within a short period of time after a traumatic event (two to three hours)" as a "Major Responsibility" of the position.

⁷³ The pocket reference cards were developed out of research conducted by academics from the Universities of Ryerson and Toronto and Mount Sinai Hospital in Toronto. The cards advise employees to be mindful of red flags such as calls that feel surprising, dangerous, overwhelming or beyond one's control, as well as calls that make the member feel ineffective, unappreciated, sad, angry or evoke other distressing feelings. Possible symptoms that may be experienced are also listed, such as sweating, shaking, trouble breathing and "feeling spaced out or out of your body." Suggestions as to what to do include seeking or accepting support, talking (if it helps) or requesting downtime.

328. Currently, the process for notifying the staff psychologist and/or the Peer Resource Team is left to the discretion of the superintendent and the duty officer. My investigators were advised that, by virtue of the fact that the service has had a staff psychologist for some time, staff "know" how to contact these supports.
329. We heard a variety of concerns about the lack of a formal notification process. Some raised the issue that leaving the decision to the discretion of the superintendent was not appropriate "because some people will be comfortable sharing that with their supervisor, some aren't." Although we heard from some superintendents that they would be able to tell if a member was impacted by a call, my office obtained evidence from paramedics suggesting that this was not necessarily the case.
330. It should also be noted that we were told superintendents have considerable workloads that might impact their ability to 'check in' on their crews. Although they try their best, it remains a challenge. One member of the Peer Resource Team explained that superintendents:
- ...they've got so much on their plate that it's difficult to cleave time over a 12 hour day to say, are you really okay?...On a Friday night, with four road supervisors on duty, at 3 o'clock in the morning when all of your shootings and stabbings and all that stuff happens, it's difficult for a supervisor to cleave an hour out of their time, book a crew out of service and not have them service calls to make sure that the paramedics are okay when there's all these other things going on.*
331. Another member of the Peer Resource Team described the current arrangement of notifying the team as "hit or miss" and is largely dependent on the duty officer or superintendent on shift. This peer member noted that he had spoken to staff that had been the recipient of a courtesy check after the Peer Resource Team was notified and they really appreciated it. But he had also spoken to paramedics that indicated they had done similar calls but never received a courtesy check; "and they get pretty down about that."
332. Another Peer Resource Team member told us that although he had spoken with duty officers about the need to notify the peer team of certain incidents, he routinely sees "big calls" in the news that the team was not notified about. This member felt that the lack of an "official process" to reach out to staff after significant calls was problematic.
333. The staff psychologist has found identifiable benefits associated with the implementation of a proactive model of psychological care. This includes increased receptivity by members to seek support earlier after symptoms and stressors first appear. She also reported that early intervention had resulted in a reduction in absenteeism and the need for longer-term counselling.

334. As noted by another Peer Resource Team member, the less opportunity the staff psychologist or members of the Peer Resource Team have to respond to a staff member, the more likely this member will not reach out for support:

You have to have a way to capture the crisis calls and the stress calls. Every one of those ones you miss, you risk sending somebody home without a level of support which is happening now. People are going home, festering, not knowing what's out there to help them. You have to have as close to 100 percent capture of these incidences.

335. The creation of a formal notification protocol is a sensible and worthwhile endeavour. Evidently, TPS concurs, given documents indicating attempts to implement such a protocol. TPS may want to consider what other services have done, where supervisors are provided with factors to consider when coming to a decision on whether to commence the notification procedure. (Recommendation 10)
336. TPS should also take steps to ensure the provision of support for employees who are involved in 'after hours' incidents. (Recommendation 11)

9.6 Keeping Track of Calls and Absences

337. One of the Ontario chiefs told my investigator that his service had recently launched an initiative to examine past service calls as a way of being proactive in providing assistance. For instance, if a review of past calls uncovered that a paramedic had done a series of Vital Signs Absent calls involving babies, or cardiac calls with poor outcomes, the service could proactively reach out to the member to check in and, if needed, offer support.
338. As noted earlier, peer support coordinators with the Victoria Ambulance receive a report of the previous day's potentially traumatic incidents and then initiate peer contact with members involved in those incidents.
339. Dr. Bender spoke to my investigator about the importance of monitoring and documenting the impact that cumulative stress can have on an individual, particularly within the first responder environment. As he explained, it is not necessarily a single call that triggers a stress injury, but rather a culmination of calls, particularly ones that are known to be more distressing, such as when children are involved.

Any first responder organization, they need to be tracking. One of the aspects that's been endemic or problematic is because it's such a 'normal' part of the job to deal with traumatic type calls (first responder organizations) actually haven't been recording them, writing them down or doing injury reports or incident reports. And then an individual will reach

some point where they feel unable to cope due to workplace exposures but there's virtually no documentation to substantiate that.

340. A chief from an Ontario paramedic service told my investigator that his service had recently created a Standard Operating Procedure requiring documentation to be completed after certain 'critical calls' to track these incidents, which could potentially be used to make a traumatic mental stress claim to the WSIB.
341. Although TPS keeps track of Medical Stress Leave hours for paramedics, and completes WSIB documentation when a paramedic goes off on Medical Stress Leave, neither the staff psychologist nor members of the Peer Resource Team are provided with information about employees that are absent due for this reason.
342. According to the staff psychologist, providing psychological support retroactively to members makes it more difficult to mitigate the distress experienced by a member.
343. In keeping with the focus of TPS to be more proactive in the provision of psychological supports, the service should institute measures to complement the notification protocol. The staff psychologist and members of the Peer Resource Team should be made aware when a paramedic goes off on Medical Stress Leave to determine whether possible early psychological intervention may be needed. (Recommendation 12)
344. The service should also consider implementing a tracking system for calls or incidents where employees have requested support from the staff psychologist and/or the Peer Resource Team (Recommendation 19)

9.7 Contact with Employees on Leave

345. In October 2011, as part of a broader strategy to improve attendance, TPS initiated 'Wellness Checks' for staff absent from work due to illness or injury.
346. Wellness Checks are to be conducted by the superintendent for the respective employee during the employee's absence from work. According to a TPS memorandum, the intent behind the check "is not to question why the employee is absent, but to demonstrate concern for the employee's well-being and to ensure that staff who are absent from work know that they are missed."
347. We heard from commanders as well as superintendents that the intent behind instituting Wellness Checks was in response to calls from the union that management did not reach out to employees who are absent due to illness/injury.
348. Some paramedics and dispatchers advised my office that they had been away from the workplace on long-term illness and never received a call from TPS to

inquire how they were doing. However, for some of these employees, they could recall receiving a Wellness Check after they had booked one shift off due to an illness, like a cold, and had only been away from the workplace for a matter of hours.

349. One paramedic shared with us her frustrating exchanges with her manager after receiving a Wellness Check following her absence from work for a matter of hours, yet had never been contacted when she was off on long term leave to address an injury. This paramedic felt that it was precisely when a member is off on an extended absence from work that a check in from someone would be beneficial.
350. A member of the Peer Resource Team who has had to take an extended break from work for physical injuries, recalled feeling "isolated" from the combination of being off and not being in contact with work. Another member who was also away from work for a period of time recalled what it felt like to receive a call from the organization during his absence:

It made me feel like I was a valued member of Toronto Paramedic Services. It didn't make me feel expendable...That, hearing from work and hearing 'How are you doing?' makes you feel like you're valued...

351. Dr. Bender noted there is a strong "role identity" within the emergency medical services, and that it is very important to maintain an organizational connection with members who are away due to illness or injury. He believes that a first responder organization should have a protocol about initiating and maintaining communication with members. In general, he commented, no communication with an absent member is detrimental, unless they have requested specifically not to receive any contact.
352. A Peer Resource Team member acknowledged to my investigator that the service "doesn't do so well in the long-term stuff" with respect to maintaining contact and that this should be rectified, perhaps through the staff psychologist. Some peer members thought that having a member of the team contact staff would be a "perfect" fit – "It's coming from somebody who has no interest, or no power...It's honestly just checking up on them."
353. The service should implement a contact protocol for employees absent either on a short or long-term basis. Such a protocol should be entirely separate from attendance improvement initiatives, like the Wellness Checks. Consideration should be given to having members of the Peer Resource Team or the staff psychologist initiate these contacts. (Recommendation 13)

9.8 Confidentiality of Psychological Services and Supports

9.8.1 Confidentiality of Services Provided by the Staff Psychologist

354. The confidentiality of services provided by the staff psychologist was an issue that came up repeatedly during this investigation.
355. Confidentiality is listed as a Term and Condition in the current staff psychologist's contract, although the requirements are not clear. The contract states that the City and TPS recognize that the staff psychologist must adhere to the relevant legislation and standards governing the practice of psychology in Ontario and that confidential information must not be disclosed except as permitted by law. The contract includes reference to the *Municipal Freedom of Information and Protection of Privacy Act* and that personal information may only be disclosed in certain circumstances, for example, when the employee provides consent.
356. The evidence obtained by my investigators suggested that there was not a broad understanding of the limits of what information the staff psychologist can and cannot provide.
357. One of the managers we interviewed complained about the lack of "transparency" with the staff psychologist's position "in terms of confirming that she has talked to the employee or talked to somebody and could confirm that this is what's going on." This individual explained that her concerns had to do more with employees indicating that they would be speaking with the staff psychologist during work hours but the manager was not able to get confirmation from the staff psychologist:
- It's like, why is this employee at headquarters when he's supposed to be over here? Oh, okay, he's up seeing the staff psychologist. But we didn't know that. So, one thing leads to another and we just become aware of situations, try to follow up on situations. I think the confidentiality was actually too much. I need to know, as a steward of the city (what my staff are doing).*
358. Another manager commented that he felt it was "tricky" dealing with the psychologist since he was unsure what could be shared with him. He recalled a time when he suggested a staff member that was struggling speak with the staff psychologist. He expected there would be feedback so that he could assist the employee. He commented on what he felt was a "shroud of mystery" surrounding this process. "And I get the need for that privacy, that veil of privacy," he said. "But you don't know how far it needs to extend."
359. Asked if he would expect to get the information that he would have liked to receive had the staff member been seeing an external clinician, he responded in the negative. However, he thought that, on account of the "professional"

relationship the staff psychologist had with the organization, that the arrangement could be different.

360. The staff psychologist advised my investigators that she is continually educating staff about confidentiality and felt that it would be helpful to come up with a definition and parameters that would outline, for example, appropriate information to be shared. She felt that would be beneficial for both management and employees because it would clearly outline how employee confidentiality is protected. She believes that employees get concerned when they hear that information is being reported by the staff psychologist to the employer.
361. Section 3.2 of the College of Psychologists' *Standards of Professional Conduct* is titled "Clarification on Confidentiality and Professional Responsibility to Individual Clients and to Organizations." It provides the following direction to psychologists:
- In situations in which more than one party has an appropriate interest in the psychological services rendered by the member to a client or clients, the member shall, to the extent possible, clarify to all parties prior to rendering the services the dimensions of confidentiality and professional responsibility that shall pertain in the rendering of services.*
362. One of my investigators followed up with the College to obtain clarification. We were advised that the expectation of the College is that organizational psychologists ensure that clients understand the parameters for the collection, use and disclosure of personal health information, in accordance with *Personal Health Information Protection Act*, and understand with whom this information might be shared. Psychologists, the College advised us, would also assume responsibility for ensuring that this communication took place with clients and that informed consent was obtained.
363. TPS has not developed a formal statement governing confidentiality of the staff psychologist. This should be attended to immediately. My office received sufficient evidence to suggest that, at the very least, there is confusion about the boundaries of confidentiality surrounding the role. A statement about the confidentiality of services provided by the staff psychologist is not about allowing a manager to keep track of the whereabouts of his or her staff, but about providing clear and understandable organizational boundaries.
364. The service should also give consideration to consulting with first responder organizations that employ in-house psychologists, like the Calgary Police Service, the Toronto Police Service, and the London Ambulance Service⁷⁴, as part of the process of developing their statement on confidentiality.
(Recommendation 17)

⁷⁴ It should be noted that the practice and regulation of psychology differs across jurisdictions. This should be taken into account when obtaining information from jurisdictions outside of Ontario.

9.8.2 Provision of Statistics and Wellness Trend Information

365. One of the expectations of the staff psychologist is that her role will provide the senior management team with "confidential service reports" to identify trends and make recommendations to address personnel and organizational needs.
366. Members of the senior management team explained to my investigators that what they hoped to obtain from the staff psychologist was "wellness trend information" regarding consultations with staff so that they could gain a better understanding of the issues.
367. My investigators reviewed an August 2009 document that summarized a meeting the second staff psychologist had with a Deputy Chief. It appears that the purpose of the meeting was to clarify the expectations of management with regard to information that it wished to receive. The document indicates that TPS wanted the staff psychologist to, among other things, "identify types of social psychological issues that emerge" and "identify the trouble points or factors that contribute to these issues" as well as "suggest interventions that TEMS might consider as mitigation strategies."
368. The first staff psychologist told investigators that all that she provided to the service were "numbers", such as the number of employees that she had met with. She recalled that she did not provide any "feedback" to the service based on her consultations with staff, as she didn't feel that was appropriate for the position.
369. She explained that, in her opinion, if the position of the staff psychologist is used as a "conduit for feedback about complaints" then this starts to blur the boundaries of the role of the psychologist as someone to provide support for employees of the service. She believed that the service should have mechanisms in place to obtain feedback from staff on organizational and operational issues that may be causing stress.
370. Senior management told my investigators that there has never been a desire to obtain confidential clinical information about employees. Rather, they are hoping for general wellness trend information that the service could potentially use to improve psychological health and wellness of employees.
371. Some services that we spoke with highlighted the positive experiences they had using online surveys to obtain feedback on the types of stressors experienced by staff. We also spoke with a researcher involved in conducting a survey to assess the health of staff at an Ontario paramedic service. My investigator was told that the results suggested online surveys were an effective means of assessing the types of stressors experienced by staff. The OPP has also used online survey

tools to measure stress among staff as a means to developing programs and strategies.⁷⁵

372. I think it would be useful for TPS to explore the use of staff surveys and online tools as a way to obtain general health and wellness information. The staff psychologist has reported to senior management that the best source of information in her view had been the anonymous survey she conducted as part of annual education sessions. In fact, the feedback obtained through this survey was used by the psychologist to redevelop the Peer Resource Team. Other services, as noted above, have successfully used staff surveys and online tools to identify general staff health and wellness issues. (Recommendation 20)

9.8.3 Geographic Confidentiality – The Location of Psychological Services

373. As mentioned earlier, the location of psychological services could, for some employees, be an influencing factor whether they seek assistance or not.
374. The office for the staff psychologist is located on the second floor of TPS headquarters, close to an elevator and stairwell. The contract for the current staff psychologist states that she will be provided with a second office, at a mutually agreeable location, on City of Toronto property. This has not been provided.
375. A former Deputy Chief explained the idea of providing an office "in a very open area" at headquarters was to allow her to be "accessible" to staff that wished to see her. The second staff psychologist, he told us, had a small office in the back of Headquarters in which he never saw anybody in, since he was mainly offsite meeting with staff at "coffee shops and so on." The service wanted to change the perception of the staff psychologist from someone as "out there" on his or her own, to someone that was a part of the service to help improve the psychological health and wellness of the organization. Having an office at headquarters, it was believed, would help change this perception.
376. The same Deputy Chief told my investigators the contract provision for a second office at an offsite location was to allow the staff psychologist to have a "private spot" in case a member wished to speak with her but was not comfortable coming to headquarters to do so.
377. The first staff psychologist advised that she declined the offer to have an office at TPS headquarters and that she "visited like everybody else." She had places offsite where she could meet people and would also on occasion pay for offsite locations out of her own funds, unbeknownst to the service.

⁷⁵ Ontario Ombudsman report, *supra* note 4 p. 75.

378. The current staff psychologist said that for employees who are not comfortable coming to headquarters she can meet them offsite, although, depending on her schedule, there may be limitations. She noted it was "not ideal" to meet with employees at coffee shops or parks, and that she has done so "many times over."
379. We heard from paramedics and dispatchers that there was a concern over confidentiality in attending headquarters to see the staff psychologist. Some members of the Peer Resource Team also relayed concerns they had received from staff about contacting the staff psychologist because her office was located at headquarters.
380. The location of the office for the staff psychologist is a TPS decision. We found examples of first responder organizations where the offices of in-house clinicians are off-site, like the Calgary Police Service, or are on-site, as is the case of the Toronto Police Service. As mentioned in the operational stress injury briefing prepared for the Paramedic Chiefs of Canada, there is no one "correct" place for a service to locate its psychological services.
381. My investigation has found, however, that there are employees who are only willing to access the services of the staff psychologist at an off-site location. Some appear not to be seeking services at all because the staff psychologist is located at headquarters.
382. The desire to provide the psychologist with a visible and accessible office at headquarters should be commended. However, in my view it is much more important to ensure that employees can access psychological services in a confidential and secure off-site location. (Recommendation 9)

9.8.4 Strengthening the Peer Resource Team

383. According to documents created by the staff psychologist, the Peer Resource Team was reformulated to include a new selection and screening process, improved training, supervision and accountability.
384. Statistics obtained by the staff psychologist show a clear increase in the utilization rates of the Peer Resource Team compared to the previous Peer Support Team, as well as increased staff confidence in the team with regard to issues such as confidentiality, willingness to contact a team member, and using the team as a support resource.
385. Notwithstanding the success surrounding the current incarnation of the peer support model, there are no policies or guidelines that govern the role or mandate of the team or its members. In fact, when my lead investigator requested the TPS provide documents related to the Peer Resource Team, we

were only given a 2007 document that made reference to the now defunct Peer Support Team.

386. In July 2015, an "open letter" was mailed to the homes of all employees from the Peer Resource Team. The letter included information on the purpose of the team, its role as a resource, and its role in promoting awareness and acceptance of reactions to stress and trauma among paramedics and dispatchers. The letter provided contact information for every member of the Peer Resource Team.
387. TPS advised my office that its understanding was the open letter was sent to provide information to staff about the role of the team. Some members of the Peer Resource Team told my investigator that the letter was also an attempt to get "some clear direction" during the time that the staff psychologist was away on a long-term leave.
388. Similar to defining the role of the staff psychologist, TPS should do the same for the Peer Resource Team. It should not be left to members of the team to draft a letter that must then be individually mailed to staff to explain who they are and what it is they do. It is the responsibility of TPS to ensure that there is clarity and understanding throughout the service with respect to the role of the Peer Resource Team. (Recommendation 6)

9.8.5 Confidentiality of Services Provided by the Peer Resource Team

389. In the letter noted above, employees were advised that all of their interactions with members of the Peer Resource Team would be "strictly confidential."
390. Confidentiality provisions guiding members on the previous Peer Support Team required them not to reveal anything to anybody, even with respect to meeting an employee, unless that person consented. Exceptions included a requirement to report concerns that an individual might be at risk of harming him or herself or others, and suspected incidents of child abuse. The current Peer Resource Team is required to adhere to the confidentiality standards of the College of Psychologists. Members are also not to provide personal details of their interactions with peers to the staff psychologist.
391. Over and over, my investigators heard from clinicians that supports provided by peer supporters had to be "absolutely confidential." Without an assurance of confidentiality, the credibility and integrity of the peer support model could be compromised.
392. One current member of the Peer Resource Team described confidentiality as the most important principle informing the operation of the team. "Even if there's no breach of confidentiality," he said, "all it needs to be is just a perception and the whole team is gone."

393. Guidelines issued by the Mental Health Commission of Canada for the practice and training of peer support note that peer supporters should ensure that confidentiality is always protected within the legal limits and should be honoured in each and every interaction.
394. Two concerns were raised by some members of the Peer Resource Team relating to the confidentiality of their interactions with staff: the responsibilities of the peer team member if that member is also management and; a peer member being asked about their interactions with staff as part of a professional standards investigation.
395. We heard that some members of the Peer Resource Team have felt that they have been put in a compromised position by the service when asked about their interactions with staff in the capacity of a member of the Peer Resource Team. One member said that, on two occasions, superintendents have asked about the peer member's interactions with staff regarding certain calls, despite this peer member advising that the information was confidential. This peer member explained the dilemma associated with this:
- You're putting me in a bad position. You know I'm not going to say anything. I can't say anything, but now are you going to come to me about me being insubordinate or something?...They shouldn't be coming to me in any capacity asking those questions. It's terrible.*
396. The Acting Commander of the Professional Standards Unit, responsible for conducting complaint investigations against paramedics and dispatchers, advised that she has not been made aware of any situations where a member of the Peer Resource Team has been placed in a compromising situation as part of an investigation.
397. She indicated that the unit was not aware of any "boundaries" or guidelines regarding the questioning of the Peer Resource Team during investigations, although she believed that such clarity would be useful. She noted that investigators are "very careful" when interviewing members of the Peer Resource Team since they "understand that it's personal and confidential, for the most part."
398. There is currently nothing that addresses the confidentiality provisions covering interactions with members of the Peer Resource Team, nor when Peer Resource Team members are involved with internal investigations.
399. On the latter point, given that there are members of management on the Peer Resource Team, it is conceivable that peer members could be placed in situations where their duties as a manager conflict with their role as a peer resource member. If TPS wishes to preserve the integrity and durability of its

current peer model, I believe it is imperative that confidentiality provisions about the role and responsibilities of the Peer Resource Team are clearly articulated and communicated throughout the service. (Recommendation 18)

9.8.6 Here's my number, so call me maybe? Confidentiality and Telephones

400. An issue that appears to have challenged TPS is the use of cell phones and the maintenance of confidentiality for members in speaking with the Peer Resource Team.
401. At the beginning of my investigation, TPS advised that members of the Peer Resource Team use their own personal cell phones but that this was "burdensome" because of the extra charges that are sometimes incurred by members responding to requests for support. Members of the Peer Resource Team used personal phones because the use of work phones will reveal the call history at the point of invoice.
402. City of Toronto policy requires each employee's phone log to be reviewed to determine if payment for personal calls is required. Cell phone bills for work phones are subject to review by administrative staff, which for some, including the staff psychologist, raises an issue over a potential lack of confidentiality surrounding member contact.
403. In a July 2015, email to members of the Peer Resource Team, they were advised that they are eligible to accept a divisional cell phone to make peer-related phone calls and text without incurring personal expense. The email advised members that the monthly bill attached to the use of a divisional phone "needs to be signed off" and that any non-peer related calls would have to be reimbursed.
404. The email notes that the monthly bills list all outgoing phone numbers and that there was no way to change this. The author of the email, who is a member of the Peer Resource Team, noted that anyone who accepts a work cell phone "may need to ask people to call you to help protect confidentiality." This email says that members who choose to use their personal cell phones will not be eligible to receive reimbursement for peer-related calls unless there was a listing of phone calls attached to their bills.
405. Some members of management did not believe this was a significant issue because there are no names of callers attached to monthly bills. Others, however, believed that this issue did compromise the promise of being able to initiate a confidential contact with a member of the Peer Resource Team. One member of management explained:

I think knowing that there's a phone number and you're accounting for it and management gets to see it (does compromise confidentiality). It's a

matter of trust. We're not trying to be difficult. We're trying to work within the system here to find a solution...I think the fact, for a paramedic, knowing that I'm phoning on your private cell, there is some confidence in that, that it isn't a city phone; I'm calling a colleague whom I trust on their personal cell phone.

406. One of the Commanders that we spoke with believed the City's policies on this issue were a "little too restrictive" and that, for a program as important as the Peer Resource Team, "there should be exceptions made when I can give a business case as to why \$50.00 a month to some paramedics is acceptable and no, you don't need to see a bill for that."
407. Friction between the need to abide by City policies and the operation of peer support teams are not limited to Toronto. One of the chiefs of an Ontario service that we spoke with described what he felt were "impediments" to the operation of his service's peer team because of the need for the municipality to see detailed breakdowns of costs incurred. Although it took some time, his service eventually established a system that would permit for compensation to peer support members but not compromise the confidentiality of these supports.
408. TPS and the City divisions involved in this aspect of financial accountability should be able to find a workaround to this issue. I am confident there is a solution that meets the necessary fiduciary requirements balanced against the importance of confidentiality. (Recommendation 14)

9.9 Maintenance of the Peer Resource Team

409. As noted in the 2010 job profile for the staff psychologist, the position is responsible for acting as the "clinical coordinator" to a team of "peer counsellors", including the selection, ongoing training and supervision of the team. Dr. McDermott advised my investigator that much time and attention is required for the "maintenance" of peer teams, including the initial and ongoing training for members, checking in with peer members and engaging in ongoing recruitment to replace departed members.
410. According to documents that we reviewed, the second staff psychologist was responsible for the training and supervision of the former Peer Support Team, including providing some 12 hours of training per year to team members.
411. In an undated document prepared by the second staff psychologist, it was noted that "several members of the (Peer Support Team) have expressed their frustration in getting the one day a year to attend (training)." He wrote that some members argued his approach in attempting to arrange for attendance at training was not effective and "should be replaced by my directing" that members attend training. He concludes by stating that he does not believe this would be the best

approach and seeks input from management on how to ensure that all peer members can attend training.

412. Upon commencing her position with TPS, the current staff psychologist met with members of the former Peer Support Team and was advised by them that they had not received sufficient training. With the establishment of the new Peer Resource Team, the psychologist arranged for the team to receive introductory training based on standards developed by the National Organization for Victim Assistance and the International Critical Incident Stress Foundation. This training took place in 2011 and 2012.
413. A 2012 document prepared by the psychologist noted there was a need for ongoing training and supervision with members of the Peer Resource Team. It was suggested that quarterly team meetings and monthly check-ins with individual peer members would be an effective way of ensuring ongoing training and supervision of Peer Resource Team members.
414. My office was provided with emails exchanged between the staff psychologist and the Deputy Chief of Operations at various points in 2012 and 2013, on establishing a schedule to allow for the ongoing supervision of and skill-set maintenance for Peer Resource Team members. At one point, the Deputy Chief advised that a business case was needed to support the request. It does not appear that this was ever prepared. My investigators were also told by senior management that TPS has not established objectives with respect to the requirement for ongoing training and supervision of the Peer Resource Team.
415. Members of the Peer Resource Team have not received any training or direct supervision since the initial training provided in 2011 and 2012, although in September 2015, arrangements were made to have a counsellor from EAP provide the team with training on psychological first aid.
416. The lack of ongoing training and regular meetings was identified by members of the Peer Resource Team as a significant source of concern and a threat to the continued success of the program. Some of the team expressed concern that the lack of recruitment efforts to replace departed members was contributing to the 'burnout' of some peers who found themselves being used more than others.
417. Regrettably, more than a few members of the team felt that the failure to meet regularly as a team and receive ongoing training was due to a lack of support for the role of the team.
418. One member, when asked if he felt that the Peer Resource Team was supported by the service replied, "Am I supported? It's difficult to feel supported if training is not really ongoing and if the team's not being backfilled." Another member said that the team did not have the "support and overseeing structure" that would

allow it to operate the way that everyone expected. This member felt the team has "stayed stagnant."

419. Another member provided a detailed explanation as to why he believed regular meetings and better support for the Peer Resource Team was needed:

I think getting together more often, while on duty, even for four hour meetings up at headquarters or wherever, doing that at least four times a year, quarterly. What that does is it allows us to help each other, because a lot of times we're kind of on our own. We don't really reach out to each other so much to talk, but in that formal setting we do and with that part of it missing, we're kind of left too much on our own. And when you're out of the loop it's not good. It's nice to get together with (the staff psychologist) and just go over things: where are we heading? Are we bringing new members on board? Are there any other models of training that we could get? I think that's probably where the biggest improvement can happen...

420. The requirement of the staff psychologist to "maintain" the service's peer program dates back to the first staff psychologist, who told my investigators that she met with peer team members monthly to ensure that they stayed within the "boundaries" of their skills and abilities.
421. One of the paramedic chiefs that my investigator interviewed advised that his service would be "entrenching" their peer support program in policy to ensure that there is service-wide support for the program.
422. With the creation of a new Peer Resource Team program, it is imperative that the service establish a framework to support the continued growth and maintenance of the team. (Recommendation 7)
423. A full-time coordinator for the peer support program was a common feature of first responder organizations that we contacted. This was true for peer support programs for the OPP, police services in Calgary, Toronto and York Region, as well as Ambulance Victoria, New South Wales Ambulance and the London Ambulance Service.
424. Currently, one of the members of the Peer Resource Team, who is the commander rank, is acting as the 'de facto' coordinator of the Peer Resource Team, with assistance as needed from an EAP counsellor, during the staff psychologist's absence.
425. My investigators were told by senior management that having a senior ranked coordinator was helpful to providing leadership and understanding of policy, along with familiarity to navigate systems. The staff psychologist advised my investigators that a coordinator would be very helpful, assuming that proper

safeguards and boundaries are established to prevent conflicts for the coordinator.

426. A central theme from senior management to my investigators was its sense of pride about the Peer Resource Team. Creating a full-time coordinator, in my view, would reinforce the importance and value that the Peer Resource Team brings. It would ensure a locus of responsibility for the leadership and functioning of the team. This would allow the staff psychologist to oversee and support the team as necessary with minimal disruption to responsibilities.
427. My investigation found many examples of first responder organizations that employ a staff psychologist and a staff member responsible for coordinating the peer team, should the TPS need evidence of best practice in the field. (Recommendation 8)

9.10 Continuing Medical Education and Operational Stress Injury

428. All paramedics must attend Continuing Medical Education (CME), on an annual basis. My investigators were told that CME is generally delivered by the service in the spring, and then by the base hospital in the fall. The spring CME is 12 hours for both primary and advanced care paramedics, while the one in the fall is eight hours for primary care paramedics and an additional four hours for advanced care paramedics.
429. For dispatchers, we were advised that, historically, Continuing Dispatch Education consists of two-full day training sessions annually. However, the service has found it challenging to deliver this training due to funding and staffing issues and are moving towards delivering one to two hour 'modules' throughout the year.
430. When the current staff psychologist commenced her employment, she was involved as part of the 2010, 2011 and 2012 CMEs delivered by the service.⁷⁶
431. The 2010 CME featured a video of the staff psychologist introducing herself to staff and encouraging them to consider how they would like to see the role of the staff psychologist evolve. In 2011, she made a presentation at every CME group and obtained anonymous feedback from paramedics (and dispatchers at their Continuing Education) on several items related to psychological services. This included: how offers of support should be elicited; the definition of a critical incident; and nominations for members of a peer support program. In 2012, she once again provided an update on changes made to psychological services, based on feedback received from staff, and outlined the changes made to the peer support program.

⁷⁶ There were no TPS delivered CMEs in 2013 or 2014.

432. Many employees of the TPS that were interviewed for this investigation, including the Chief, reported being very pleased with the involvement of the staff psychologist as part of the CME sessions as a means to raising the profile of psychological services.
433. Many paramedics that we spoke with, including members of the Peer Resource Team, felt that it would be useful to include more education as part of CME on topics such as psychological health and wellness and issues related to operational stress injuries.
434. One member of the Peer Resource Team complained how discussions about mental health and resilience "never come up" at CME, which he thought was problematic. "We'll talk about the third rail on the TTC for an hour and a half," he commented, "but we'll never talk about people's mental health. It doesn't come up."
435. Another peer team member noted that mental health as it relates to patient care was presented at the spring 2015 CME.⁷⁷ He noted that some paramedics "might figure out that you might become one of the patients" but nothing was delivered that he could recall related to member mental health and wellness. He believed that it would be helpful for paramedics as well as supervisors for this type of education to be offered.
436. My investigator was told that that there was no coordination or formal linkages between Education and Development (responsible for delivering the spring CME) and the staff psychologist for purposes of developing training material. One member of management felt that it would be helpful for the staff psychologist to be more "engaged" in the development and delivery of topics on mental health for CME, rather than have staff "cobble" something together.
437. As for dispatchers, my investigator was told that there has not been any recent education on operational stress injuries or mental health and wellness. There is no formal linkage between the staff psychologist and the Education and Quality Improvement Unit for the Communications Centre either.
438. It is important that education on operational stress injuries take place at all stages of first responders' careers. My investigation heard there was a desire on the part of paramedics and dispatchers to obtain this type of training, and a desire on the part of management to offer it. In fact, TPS has recently requested training for management and some staff members on psychological first aid to be delivered by a counsellor from the EAP.

⁷⁷ This CME, delivered by Superintendents in the Education and Development section of TPS, offered, amongst other things, paramedics the chance to see a simulation of a psychotic episode that a person with schizophrenia might experience and strategies on how to respond to patients with psychiatric illness or mental health issues.

439. TPS should use the resources available to develop a comprehensive and coordinated education and training plan on operational stress injuries. The plan should consider the type of training for employees at all stages of their career and should be offered on a regular basis. Further, the plan should be amended, as required, to reflect best practice in the field. (Recommendation 21)

9.11 Hearing from Peers – Education and Training

440. The value of including peers with lived experience as part of training for operational stress injuries has been recognized as a means to reducing the stigma associated with mental health issues and encourage individuals to seek help.
441. One manager told my investigator about a management training session where a former paramedic spoke about living and working with mental health and addiction issues, all the while hiding it from co-workers and supervisors until things spiralled out of control. My investigator was told that, for some members of management, hearing this presentation got the "ball rolling" with regard to moving forward on implementing supports to address mental health issues.
442. My investigation also heard from individual paramedics and dispatchers, including members of the Peer Resource Team, on the value of having a peer talk about his or her personal experiences with stress injuries.
443. As part of the development of a comprehensive training plan for operational stress injuries, TPS should consider incorporating the use of peers with lived experience. This, of course, should be done in a manner that does not harm the mental health of peers and should only be done with peers that have obtained the appropriate approvals from health care providers.
444. Although we were told that there may be logistical challenges associated with having peers involved, such as timing and scheduling, consideration should be given to delivering this education in other formats, such as video, or venues, such as wellness days beyond formal training days. The service could also avail itself of resources and programs available in the community, such as Voices from the Street, to provide this education. (Recommendation 22)

9.12 Taking the Next Step - Pre-Employment Screening

445. My office's review of documents indicated multiple references about TPS implementing some form of psychological screening. This issue came up repeatedly during interviews. In one document it noted, "the sooner we get [pre-employment screening] implemented, the better."
446. The Education and Development Unit is responsible for the hiring of paramedics, while the Education and Quality Improvement Unit within the CACC hires

dispatchers. Commanders from both of these units indicated to my investigator that it would be helpful to have a connection with the staff psychologist to assist in the development of some screening tools as part of the hiring process.

447. The Chief has also indicated that he would like to see pre-employment screening as part of the hiring process but acknowledged that it would need to be quarter-backed by an "expert" to deal with issues such as human rights and the proper implementation of the screening process.
448. The implementation of a pre-employment screening process by the Ottawa Paramedic Service for dispatchers, and soon for paramedics, should serve as notice that other paramedic services are implementing innovative approaches. TPS should start the process of consulting with internal and external stakeholders, as well as other first responder organizations with experience on this issue, to consider pre-employment screening. (Recommendation 25)

9.13 In Support of the Families of Paramedics and Dispatchers

449. The first staff psychologist told my investigators that the family is the "eyes and ears" to first notice when a member may be impacted by an operational stress injury. Family members, she said, can also be seriously impacted if their loved one is struggling with an operational stress injury. She recalled that she would run evening education sessions for paramedics and their spouses. She felt that supporting families was an important part of maintaining the health of staff.
450. The current staff psychologist advised my investigators that, in her experience, she finds there is a high incidence of family/relationship-related issues involving paramedics. She said:

I've lost track of the number of times a senior male paramedic has said to me that...she spits in my face at home. These are our most proud, our most noble paramedics. You would have no clue that this is what they're dealing with at home.

451. TPS advised my office that, historically, EAP offered annual or bi-annual workshops to family members on various wellness issues, such as dealing with shift work, stress management techniques and relationship building strategies for first responder couples.
452. It is unclear why TPS has not continued with these supports. TPS should establish initiatives to address the health and wellness of employees' families. (Recommendation 23)

9.14 A Strategy to Prevent a Tragedy - Suicide Awareness, Prevention and Intervention

453. TPS is aware of three employee suicides in the past 16 years: a recruit in 1999, a paramedic in December 2007 and a paramedic in April 2014.
454. Although the service does not have a formal suicide response strategy, it does address situations where there is a risk of suicide when it becomes aware. The staff psychologist recalled a period where, approximately once a month, she would see a new referral with indications of suicidal intent, in addition to three people a month that, in her opinion, had moderate to severe suicidal ideation. One of the Peer Resource Team members advised my investigator that since the paramedic suicide death in April 2014, more employees have been seeking help with this issue.
455. Members of the Peer Resource Team have not received suicide assessment and intervention training, although my investigation has reviewed TPS documents where the need to provide this training was raised.⁷⁸ Many of the members advised my investigator that they believed it would be useful to receive suicide assessment/intervention training, with one noting that it was not "unusual when we do talk with people, sometimes the phrase comes up, someone feeling not sure whether or not they'd harm themselves." One reported feeling "over (their) head" when responding to members that have expressed suicidal thoughts.
456. Some Peer Resource Team members suggested that training on suicide awareness should be given to all members of the service. One member explained why he believed this:
- I think we all own a little bit of responsibility when something like that happens to a member of our service. None of us were given additional training to potentially recognize that, such as suicide intervention training...I'm talking from a service wide perspective, blue shirts, white shirts, peer resource members. I think something like that should be prompt for all of us to get something.*
457. Training on suicide awareness could also be beneficial for employees who might be required to respond to patients or callers who are exhibiting suicidal thoughts or behaviours. A dispatcher shared with us that she had recently had a call where a woman was standing on the edge of a balcony threatening to jump. The woman's daughter had placed the dispatcher on speaker phone to try and persuade her mother to stop from jumping.

⁷⁸ According to the *Guidelines for the Practice and Training of Peer Support* issued by the Mental Health Commission of Canada, peer supporters should receive basic training on crisis situations and strategies to respond to such situations. The guidelines also note that additional training on suicide awareness and suicide intervention is required as a follow-up session to this basic training. See <http://www.mentalhealthcommission.ca/English/document/18291/peer-support-guidelines> at pages 42 and 43.

458. The dispatcher expressed concern that she had never had any training on how to respond to these types of calls and noted that her entire call was "off-script." My investigators reviewed a 2011 draft proposal prepared, in part, by the staff psychologist to provide some of the dispatchers with training to manage distressed and suicidal callers. It does not appear that this training has been delivered.
459. Implementing proactive suicide prevention strategies is obviously important. This is not only because it could result in saving someone's life but because of the devastating impact that the death of a colleague by suicide can have on an organization. As we heard often during this investigation, "one is too many."
460. One of the Peer Resource Team members told my investigator the goal for the service should be to make sure the April 2014 suicide death of a paramedic is not repeated:

At the end of the day a person's dead...It was sad. It truly was sad. Let's not do the blame game at all, but can we prevent it. That's what you want. You never want to see this happen again.

461. The need to provide members of the Peer Resource Team with suicide assessment and intervention training has already been identified. TPS should, as a priority, ensure that members of the team receives this training, including making provisions to provide it on an ongoing basis. (Recommendation 24)
462. TPS must develop a formal suicide prevention and intervention strategy. The service should consider consulting with other organizations that have implemented these strategies, as well as research best practices. Based on evidence gathered as part of my investigation, it appears that a strategy at minimum must include immediate and expedited access to supports, support and assistance to family members, and suicide awareness training for all paramedics and dispatchers. (Recommendation 15)
463. TPS has not documented a formal protocol to address the issue of member funerals, whether by suicide or other means. We examined documents submitted to senior management by the second staff psychologist in 2009 in which it was noted that the service needed "to have a protocol for going into 'funeral mode.'"
464. We were advised that decisions surrounding funerals and memorials of deceased paramedics, including paramedics that died by suicide, is determined by the family of the deceased.
465. We were also advised that the family of a member that died by suicide is offered the same ceremony that any deceased member would be offered. This,

however, was not widely known by the staff that we spoke with throughout the investigation, including members of senior management.

466. In the lobby of TPS headquarters there is memorial wall depicting the pictures and names of deceased employees and retirees. The wall includes the names and pictures of the two paramedics that died by suicide in 2014 and 2007. This is important recognition and a respectful honouring of all TPS staff.
467. Another issue that was raised was notification to staff, including Peer Resource Team members, of the death of a colleague. Recently, a TPS paramedic died from natural causes. My investigators heard that the notification process to paramedics in the immediate aftermath of their colleague's death was swift, respectful and much appreciated. Notwithstanding, it appears to me that this process was not governed by a clear and established organizational protocol to be followed for such situations.
468. Unfortunately, in the aftermath of the 2014 death by suicide of a paramedic, there appeared to be some complications with regard to how staff were notified of the death. One Peer Resource Team member recalled that they were "shocked" at how some of the staff were "abruptly" notified that one of their colleagues had died. Another member expressed concern that there really didn't seem to be any "process and procedure" that involved a timely notification to the Peer Resource Team so it was well positioned to deliver immediate supports to employees:
- (M)ore than likely there's going to be a death of a colleague like that, and there's going to be a line of death, possibly. They're awful things but the team needs to be involved in developing a process and a procedure in place so that when these tragedies happen that we can minimize some of the collateral damage that happens out there, so that we can be notified immediately, so that we can put our antennas up for who needs help.*
469. In my view, at the very least, there must be consistency in the decision making process attached to the death of a colleague. This would include important items like notification to staff, including engaging supports such as the Peer Resource Team, and memorial arrangements for the member. Any information to be shared to staff about the death of a colleague, by suicide or otherwise, should respect the wishes of the family of the deceased. But there should also be a degree of certainty and clarity surrounding how those decisions are to be made, as outlined in a formal protocol, for the benefit of the entire organization.
470. The death of a colleague, regardless of the circumstances, can be a deeply emotional time for an organization. I believe the documentation of a formal protocol to address the various issues to be considered upon the death of a colleague would provide a modicum of closure to all of those impacted.
(Recommendation 16)

10.0 Conclusion

471. There should be no mistake that TPS is, and will continue to be, a leader among paramedic services in the delivery of services and supports to address operational stress injuries.
472. However, as my investigation findings reveal, there is work to be done by the service to address this important issue and make improvements.
473. Toronto Municipal Code Chapter 3, 3-36 provides that the Ombudsman, in undertaking an investigation, shall have regard to whether the decision, recommendation, act or omission in question may have been:
- a) Contrary to law;
 - b) Unreasonable, unjust, oppressive or improperly discriminatory;
 - c) Based wholly or partly on a mistake of law or fact;
 - d) Based on the improper exercise of a discretionary power; or
 - e) Wrong.
474. It is my opinion that the TPS' lack of a comprehensive psychological services support program to address staff operational stress injury is unreasonable, in accordance with Chapter 3, 3-36 (b) of the Toronto Municipal Code.

11.0 Recommendations

475. Taking into account all of the evidence gathered through this investigation, I am making the following recommendations:

Developing an Organizational Structure for Psychological Services

1. That TPS implement a coordinated psychological health and wellness plan for its employees. The plan should outline the role of the organization in the provision of psychological supports and services in the following areas:
 - Objectives of the service's psychological health and wellness plan, including addressing the stressors inherent to the positions of paramedic and emergency medical dispatcher;
 - Strategies to meet the objectives, including access to services, prevention, intervention, and post-incident support initiatives for employees, and addressing the stigma associated with operational stress injuries.
 - The plan should be disseminated throughout the service and included in service-wide policy and procedure manuals.
 - Coordination of efforts with external partners to support the psychological health and wellness of employees.

2. That TPS communicate to all staff the role and function of the staff psychologist, and how it fits with the larger psychological health and wellness plan.
3. That TPS, as part of the above recommendations, consider the value of employees accessing short-term assistance from a clinician familiar with TPS psychological stressors.
4. That TPS establish a formal relationship for the purposes of enhancing the support services provided by the City EAP.
5. That TPS engage with service providers to enable paramedics and dispatchers to access external psychological services.
6. That TPS document and communicate the role and mandate of the Peer Resource Team, including how the position fits with the psychological health and wellness plan.
7. That TPS establish a framework to support the growth and maintenance of the Peer Resource Team. It should include the service's commitment to ensuring training, regular team meetings, supervision, and ongoing recruitment of team members. This framework should be included in service-wide policies and procedures.
8. That TPS consider an additional management resource for the purposes of coordinating the Peer Resource Team.
9. That TPS consider the value of having an off-site location where employees can meet with the staff psychologist to receive assistance.

Policy

10. That TPS develop a protocol regarding the notification and deployment of the staff psychologist and the Peer Resource Team when the services of one or both may be required.
11. That TPS ensure psychological supports are available for employees involved in 'after hours' calls.
12. That, with the consent of the employee, TPS ensure the staff psychologist and the Peer Resource Team are made aware of employees that are absent on medical stress leave for determination of possible early psychological intervention.

13. That TPS develop a protocol to ensure that organizational contact is maintained with employees who are absent due to physical or operational stress injuries.
14. That TPS seek a solution to reimburse the Peer Resource Team members for cell phone bills associated with the delivery of peer supports.
15. That TPS develop a suicide prevention and intervention strategy.
16. That TPS document the protocol to address the death of employees, including deaths by suicide. The protocol should address issues such as staff notification, engagement of supports, and memorial services.
17. That TPS develop a policy on confidentiality with respect to accessing all or any psychological support services. The statement should be consistent with relevant legislation and standards governing the practice of psychology in Ontario.
18. That TPS issue a clear and comprehensive policy on the confidentiality provisions covering employee interactions with members of the Peer Resource Team.

Data Trends Analysis

19. That TPS implement a system to track calls or incidents where employees have requested support from the staff psychologist and/or Peer Resource Team.
20. That TPS consider tools such as staff surveys and online resources as a way to obtain general health and wellness trend information.

Education and Training

21. That TPS develop an education plan for paramedics, dispatchers and supervisors on operational stress injuries. This plan should include training for employees at all stages of their career and should reflect best practices.
22. That TPS incorporate the use of peers as part of its education plan.
23. That TPS implement education and support initiatives for family members of paramedics and emergency medical dispatchers.
24. That TPS ensure that all members of the Peer Resource Team receive suicide assessment and intervention training. TPS should also ensure that members of the Peer Resource Team receive ongoing training as required and that new members of the Peer Resource Team receive this training.

Pre-Employment Screening

25. That TPS consider, in consultation with stakeholders, implementing pre-employment screening as part of the recruitment of paramedics and emergency medical dispatchers.

Reporting Requirements

26. That TPS provide periodic updates to the Ombudsman and complete all the above noted recommendations by November 1, 2016.

12.0 Summary of the City's Response

476. Pursuant to *s. 172(2) of the City of Toronto Act, 2006*, I provided the City with an opportunity to review a draft of my investigation report, so that officials could respond to the tentative findings and recommendations.

A number of discussions were held with the Chief of TPS and his staff to receive their feedback. Subsequently, my office met with TPS officials and the City's Deputy City Manager on November 10, 2015 in which any outstanding matters were clarified.

The City Manager responded in writing on November 12, 2015 (see Appendix A). In that response, the City accepted all recommendations and reiterated its commitment to implementing the recommendations for the benefit of staff.

(Original signed)

Fiona Crean
Ombudsman
November 13, 2015

Appendix A: The City's Response



Peter Wallace
City Manager

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November 12, 2015

Fiona Crean
Office of the Ombudsman, City of Toronto
375 University Avenue, Suite 203
Toronto, Ontario M5G 2J5

Dear Ms Crean:

Re: File #8015 – "Making the Strong, Stronger" - An Investigation into how Toronto Paramedic Services addresses staff operational stress injuries

Further to your request, please find below the City's response to your investigative report on how Toronto Paramedic Services addresses operational stress injuries affecting its staff.

We found your investigation to be comprehensive and helpful to the Division. We are in agreement with the recommendations that you have made and Paramedic Services is committed to implementing these recommendations for the benefit of its staff.

The Division is already taking several proactive steps to address the issues identified in your report and to strengthen the psychological support services for staff.

Toronto Paramedic Services has:

- Identified a project team to ensure the coordination of its psychological support services and the implementation of your recommendations;
- Initiated training for management staff and the Peer Resource Team to enhance support for employees;
- Scheduled psychological support training for all staff in 2016, in particular, those on the frontline;
- Begun consulting with industry experts and other emergency services on best practices in the provision of psychological support services; and
- Been working closely with the City of Toronto Human Resources Division to strengthen our existing program.



Thank you for the opportunity to provide our comments on your report. The division and my staff also very much appreciated the opportunity to meet in person with you and your staff to discuss your findings.

Toronto Paramedic Services looks forward to working with the Ombudsman's Office in the implementation of your recommendations.

Yours Truly,



Peter Wallace
City Manager