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**Z1003.1-18**

# **Psychological health and safety in the paramedic service organization**



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***Psychological health and safety in  
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# Preface

This is the first edition of CSA Z1003.1, *Psychological health and safety in the paramedic service organization*.

This Standard provides paramedic service organizations and other key stakeholders with guidance on good practice for the identification and assessment of hazards and management of psychological health and safety (PHS) risks for paramedic service organizations and the promotion of improved psychological health and safety.

This Standard builds on CAN/CSA-Z1003-13/BNQ 9700-803/2013, *Psychological Health and Safety in the Workplace* and provides a systematic approach to the management of PHS hazards and their related risks for paramedic service organizations and offers practical, relevant guidance to help protect and promote the psychological health and safety of workers in Canada.

In addition to following the structure of CAN/CSA-Z1003/BNQ 9700-803, this Standard is compatible with other management system standards, and the Plan-Do-Check-Act (PDCA) approach.

The Standard is an evidence-informed document that encompasses existing CSA Standards, government policy documents, peer-reviewed research articles, and non-peer-reviewed materials. The source materials are primarily from Canada, but a few from other countries have been included. Unlike an academic publication, in-text citations are not included with the Standard; a complete list of resources can be found in Annex J.

This Standard was commissioned by the Paramedic Association of Canada (PAC) and supported through funding from the Ontario Ministry of Labour's Occupational Health and Safety Prevention and Innovation Program (OHSPiP). The views expressed in this Standard do not necessarily reflect those of the Ontario Ministry of Labour.

This Standard was prepared by the Technical Committee on Paramedic Psychological Health and Safety, under the jurisdiction of the Strategic Steering Committee on Occupational Health and Safety, and has been formally approved by the Technical Committee.

## Notes:

- 1) *Use of the singular does not exclude the plural (and vice versa) when the sense allows.*
- 2) *Although the intended primary application of this Standard is stated in its Scope, it is important to note that it remains the responsibility of the users of the Standard to judge its suitability for their particular purpose.*
- 3) *This Standard was developed by consensus, which is defined by CSA Policy governing standardization — Code of good practice for standardization as “substantial agreement. Consensus implies much more than a simple majority, but not necessarily unanimity”. It is consistent with this definition that a member may be included in the Technical Committee list and yet not be in full agreement with all clauses of this Standard.*
- 4) *To submit a request for interpretation of this Standard, please send the following information to [inquiries@csagroup.org](mailto:inquiries@csagroup.org) and include “Request for interpretation” in the subject line:*
  - a) *define the problem, making reference to the specific clause, and, where appropriate, include an illustrative sketch;*
  - b) *provide an explanation of circumstances surrounding the actual field condition; and*
  - c) *where possible, phrase the request in such a way that a specific “yes” or “no” answer will address the issue.*

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- 5) *This Standard is subject to review within five years from the date of publication. Suggestions for its improvement will be referred to the appropriate committee. To submit a proposal for change, please send the following information to [inquiries@csagroup.org](mailto:inquiries@csagroup.org) and include "Proposal for change" in the subject line:*
- a) *Standard designation (number);*
  - b) *relevant clause, table, and/or figure number;*
  - c) *wording of the proposed change; and*
  - d) *rationale for the change.*

# Z1003.1-18

## ***Psychological health and safety in the paramedic service organization***

### **0 Introduction**

#### **0.1 Background**

A psychologically healthy and safe workplace is one that actively works to prevent harm to workers' psychological health, including in negligent, reckless, or intentional ways, and that promotes psychological well-being. In 2013, a National Standard of Canada was published by the CSA Group and the Bureau de Normalisation du Québec (BNQ), commissioned by the Mental Health Commission of Canada (MHCC) and supported through funding by the Government of Canada, Bell Canada, and the Great-West Life Centre for Mental Health in the Workplace. CAN/CSA-Z1003/BNQ 9700-803 was created to help organizations recognize psychological health as part of an ongoing process of continual improvement.

This Standard builds on CAN/CSA-Z1003/BNQ 9700-803 and provides a systematic approach to the management of psychological health and safety (PHS) hazards and their related risks for paramedic service organizations and offers practical and relevant guidance to help protect and promote the psychological health and safety of paramedic service organizations, which includes, but is not limited to, paramedics, fleet/logistics employees, dispatchers, and administrative staff in Canada. This Standard incorporates supplementary requirements emphasizing the unique aspects of paramedic service organizations. These requirements have been developed separately to ensure that they are clear and relevant for paramedic service organizations.

There are approximately 40 000 paramedics in Canada, making them the third largest group of healthcare providers in the country. The unique responsibilities and challenges faced by paramedic workers and the significantly increased risk of exposure to psychological stress are well recognized. The psychological hazards that workers are routinely exposed to at work can be acute or chronic in nature and can include, but are not limited to, operational stressors such as trauma, severe injuries and illness, child health crises, death, violence, and threats to their own lives. In addition, organizational stressors common to many other work environments, such as poor communication, issues related to remuneration, high emotional demands, lack of social support from colleagues and management, physical strains, and poor job autonomy can be associated with adverse outcomes. It has also been shown that a link exists between these stressors and the potential development of various types of mental health problems.

These acute and chronic stressors put workers at risk for a wide range of mental health problems, including, but not limited to acute stress disorder, posttraumatic stress, depression, anxiety, anger, and burnout. Such problems can lead to, or be coincident with, other negative outcomes, such as suicide, substance misuse, addictive behaviours, relationship difficulties, and absenteeism.

The intent of this Standard is to safeguard against the harmful effects of unchecked or unrecognized stressors and/or trauma. The positive impact of improving psychological health in the workplace is far reaching. This includes, but is not limited to, the maintenance and improvement of relationships, family

dynamics, quality of life, engagement in leisure pursuits, healthy lifestyle, work-life balance, job satisfaction, job performance, and optimal patient care.

Recent Canadian research has been conducted to better understand the unique psychological needs of paramedics and communication officers and identify evidence-informed effective interventions and preventive measures. Meanwhile paramedic service organizations are looking to tools and resources that can be tailored to meet the needs of the paramedic community. This sector-specific standard will help paramedic service organizations to systematically identify sources of stress, examine changes that could be made, and build policies and programs that address psychological health and safety (PHS).

## 0.2 Approach

In the development of this voluntary Standard, the Technical Committee has recognized that the requirements and complexities of paramedic service organizations and workers vary considerably. The Technical Committee also recognizes that implementation of a standard is not a “yes/no” response but rather a journey of continual improvement.

The Standard provides clause by clause text of Clauses 4 and 5 from CAN/CSA-Z1003/BNQ 9700-803 followed by specific paramedic content. The additional paramedic sector-specific requirements and guidance are distinguished from the CAN/CSA-Z1003/BNQ 9700-803 Standard by the symbol **P** in the margin.

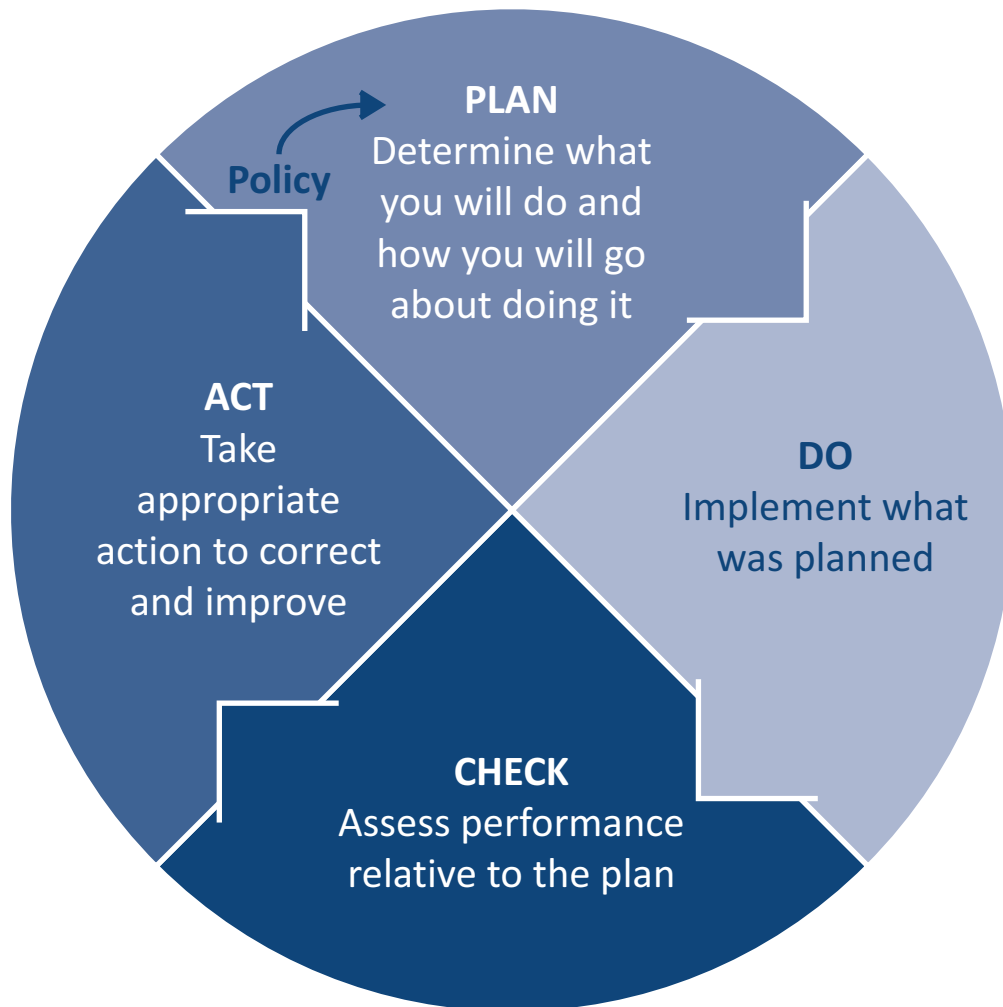
The supporting annexes (Annexes **A** to **J**) contain informative guidance material to assist users in implementing and meeting the normative requirements within this Standard. When the text from CAN/CSA-Z1003/BNQ 9700-803 makes reference to an annex, that reference is not applicable to the paramedic content.

This Standard has been developed with the expectation that it can be used by an organization to conduct its own review. It enables the organization to make a self-declaration that it conforms to the requirements of this Standard. This Standard may also be used as a guide by others who are external to the organization. External assessment of conformity with this Standard may be used to verify self-declaration.

## 0.3 Psychological health and safety management system (PHSMS)

A psychological health and safety management system (PHSMS) helps an organization to identify and mitigate hazards that can contribute to psychological harm to the worker. It is a preventive approach that assesses a workplace’s practices and identifies areas of concern. When concerns are noted, the organization implements strategies for preventive measures that are designed to reduce potential harm and mitigate or eliminate hazards. It is recognized that there are hazards that cannot be eliminated from the work; however, the PHSMS can be focused on minimizing risk, addressing early awareness, and ensuring evidence-informed intervention practices and appropriate support. This management system approach is the basic framework of this Standard (see Figure 1) and guides an organization to develop a PHSMS system that is unique to their requirements and workplace issues.

**Figure 1**  
**Management system framework**  
 (See Clause 0.3.)



#### 0.4 Overview

This Standard has been written so that it is consistent with other guidance and specifications that are used by organizations to manage psychological health and safety, occupational health and safety, and quality, but expands on the specific needs for managing psychological health and safety risks in paramedic service organizations.

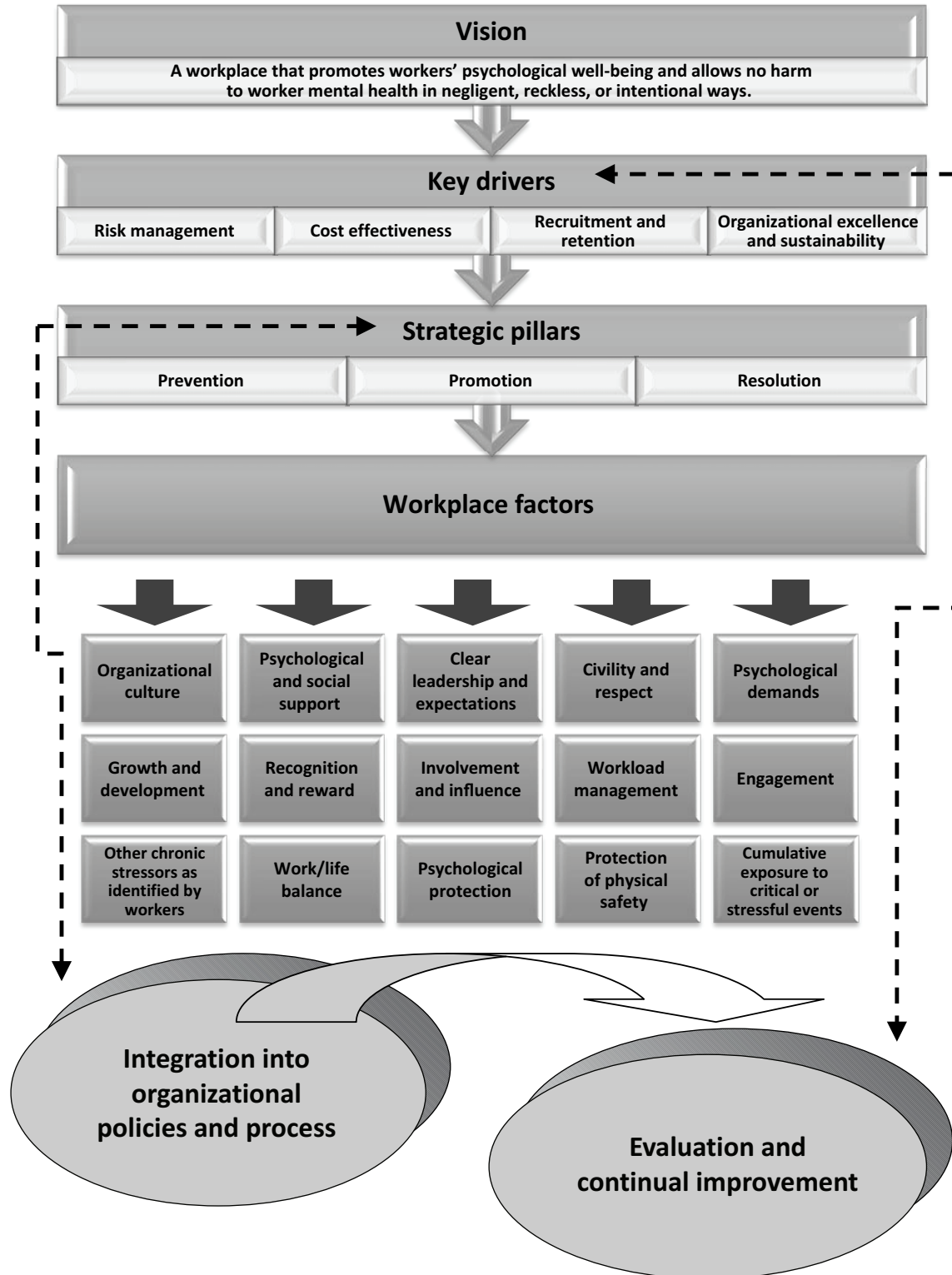
The strategic pillars of a PHSMS are

- prevention of harm (the psychological safety of workers);
- promotion of health (maintaining and promoting psychological health); and
- resolution of incidents or concerns.

See Figure 2, which illustrates a planned approach to address workplace factors known to impact psychological health.

This Standard provides requirements, recommendations, and guidance to enable paramedic service organizations to develop, implement, and monitor a systematic approach to psychological health and safety for their workplaces. The aim is to identify potential areas and activities that give rise to occupational stressors and implement measures before harm can occur.

**Figure 2**  
**Model of a planned approach to address workplace factors known to impact psychological health**  
 (See Clauses 0.4 and B.2.)





## 0.5 Application

The requirements in this Standard can be incorporated into any occupational health and safety (OHS), quality management, or PHS management system or be implemented on their own. The extent of the application will depend on such factors as the OHS/PHS policies of the organization, the nature of its activities, and the hazards and related risks and complexity of its operations.

The paramedic service organization may apply this Standard to other workers in the organization who could be exposed to PHS hazards associated with their roles and activities, such as 9-1-1 communication officers (i.e., call-takers and dispatchers) and fleet and administrative staff. In addition, this Standard provides some guidance and information for paramedic service organizations in supporting family members as part of the wider paramedic community.

# 1 Scope

## 1.1 Purpose

This Standard provides paramedic service organizations and other key stakeholders with requirements and guidance on good practice for the identification and assessment of hazards and management of psychological health and safety (PHS) risks for paramedic service organizations and the promotion of improved psychological health and safety.

This Standard is applicable to any paramedic service organization that seeks to

- a) establish a program to eliminate and/or minimize workplace PHS risks to paramedics and other workers of the organization;
- b) enhance psychological well-being;
- c) implement, maintain, and continually improve a program for PHS;
- d) assure itself of its conformity with its stated PHS policy; and
- e) demonstrate conformity with this Standard.

## 1.2 Exclusions

This Standard is aimed at the employer (i.e., the paramedic service organization) and provides guidance at an organizational level. It does not provide guidance on the diagnosis and treatment of workplace-related mental health problems of workers.

While similar risk factors exist for other categories of first responders (i.e., firefighters, police officers) and public safety officers, workers in paramedic service organizations face unique issues directly associated with the nature of the care they deliver. Their exposure to trauma is different from other first responder and public safety workplaces. While this Standard could be used by other first responder organizations as a model for the development of PHS programs, the guidance provided in this Standard is specific to paramedic occupational environments.

It is not within the scope of the PPHS Standard to provide requirements for equipment and vehicle design, equipment standards, workplace ergonomics, personal protective equipment (PPE), or emergency management programs.

## 1.3 Guiding principles

This Standard is based on the following guiding principles:

- a) legal requirements associated with psychologically healthy and safe workplaces applicable to the organization will be identified and complied with as a minimum standard of practice;

- b) psychological health and safety is a shared responsibility among all workplace stakeholders and commensurate with the authority of the stakeholder;
- c) the workplace is based on mutually respectful relationships among the organization, its management, its workers, and worker representatives, which includes maintaining the confidentiality of sensitive information;
- d) individuals have a responsibility towards their own health and behaviour;
- e) a demonstrated and visible commitment by senior management for the development and sustainability of a psychologically healthy and safe workplace;
- f) active participation with all workplace stakeholders;
- g) organizational decision making incorporates psychological health and safety in the processes; and
- h) a primary focus on psychological health, safety, awareness, and promotion as well as the development of knowledge and skills for those persons managing work arrangements, organization, processes, and/or people.

Activities associated with this Standard, specifically related to planning, data collection, and evaluation requirements, are to be conducted in a psychologically safe, confidential, and ethical manner.

**Note:** *In support of developing guiding principles and values consistent with their mission and vision and local environment, paramedic service organizations should consider the following:*

- a) *occupational and operational stressors for paramedic workers can have a significant impact on their lives, personal and professional relationships, potentially affecting co-workers, patients, families, and friends. Paramedic service organizations should take an integrated, holistic, and broad approach, including how to involve family members where applicable. Prevention strategies should be part of a support continuum and include all of those individuals who could be impacted (family could include other significant individuals outside of the workers' immediate family members (e.g., partner, significant other, care-taker, etc.);*
- b) *paramedic service organizations need to consider strategies to identify hazards and workplace factors and risk assessment to control risk at the organizational, team, and worker level. Some workplace factors and inherent risk are part of the paramedic role. Strengthening protective measures can help to mitigate the impact of the hazards where and when they occur and can promote psychological health and safety on many levels; and*
- c) *mental health difficulties can affect a paramedic worker at any point in his/her career. The paramedic service organization should consider the psychological health and safety of the workers at all times in their career (e.g., recruitment, operational service, promotion, return-to-work, and leaving the service).*

## 1.4 Terminology

In this Standard, “shall” is used to express a requirement, i.e., a provision that the user is obliged to satisfy in order to comply with this Standard; “should” is used to express a recommendation or that which is advised but not required; and “may” is used to express an option or that which is permissible within the limits of this Standard.

Notes accompanying clauses do not include requirements or alternative requirements; the purpose of a note accompanying a clause is to separate from the text explanatory or informative material.

Notes to tables and figures are considered part of the table or figure and may be written as requirements.

Annexes are designated normative (mandatory) or informative (non-mandatory) to define their application..

## 2 Reference publications

This Standard refers to the following publications, and where such reference is made, it shall be to the edition listed below, including all amendments published thereto.

### CSA Group

CAN/CSA-Z1000-06 (R2011)

*Occupational health and safety management*

CAN/CSA-Z1001-13

*Occupational health and safety training*

CAN/CSA Z1002-12 (R2017)

*Occupational health and safety — Hazard identification and elimination and risk assessment and control*

CAN/CSA-Z1003-13/BNQ 9700-803/2013

*Psychological health and safety in the workplace*

### American Psychiatric Association

DSM-5, 2013

*Diagnostic and Statistical Manual of Mental Disorders*

### BNQ (Bureau de normalisation du Québec)

BNQ 9700-800

*Health Promotion Glossary*

### COMH (Consortium for Organizational Mental Healthcare)

*Guarding Minds @ Work*, Faculty of Health Sciences, Simon Fraser University, 2009:

<http://www.guardingmindsatwork.ca/eng/info/index>

### ISO (International Organization for Standardization)

*ISO Guide 73*

CAN/CSA-ISO 19011

### Mental Health Commission of Canada

*Guidelines for the Practice and Training of Peer Support*, 2013:

[mentalhealthcommission.ca/English/focus-areas/peer-support](http://mentalhealthcommission.ca/English/focus-areas/peer-support)

*Report — Case Study Research Project Findings*, 2017

### Other publications

Greenstone, J. L. 2000. Peer support in a municipal police department: Doing what comes naturally. *The Forensic Examiner*, 9(3-4): 33–36.

Grenier, S., Darte, K., Heber, A., and Richardson, D. 2007. The operational stress injury social support program: A peer support program in collaboration between the Canadian Forces and Veterans Affairs Canada. In C. R. Figley and W. P. Nash (Eds.), *Combat stress injury: Theory, Research, and Management*. New York, NY: Routledge, Taylor and Francis Group.

Kemp, V., and Henderson, A. R. 2012. Challenges faced by mental health peer support workers: Peer support from the peer supporter's point of view. *Psychiatric Rehabilitation Journal*, 35(4): 337–340.

Mead, S., Hilton, D., and Curtis, L. (2001). Peer support: A theoretical perspective. *Psychiatric Rehabilitation Journal*, 25: 134–141.

Mitchell, J. T. 1983. When disaster strikes...The critical incident stress debriefing process. *Journal of Emergency Medical Services*, 8: 36–39.

Solomon, P. 2004. Peer Support/Peer Provided Services Underlying Processes, Benefits and Critical Ingredients, *Psychiatric Rehabilitation Journal*.

## 3 Definitions and abbreviations

### 3.1 Definitions

The following definitions shall apply in this Standard:

**Notes:**

- 1) For the purposes of this Standard, the term “organization” refers to a paramedic service organization.
- 2) For the purposes of this Standard, the term “worker” is inclusive of the paramedic.

**Acute stress disorder** — exposure to actual or threatened death, serious injury, or sexual violation in one (or more) of the following ways:

- a) directly experiencing the traumatic event(s);
- b) witnessing, in person, the event(s) as it occurred to others;
- c) learning that the event(s) occurred to a close family member or close friend; and
 

**Note:** In cases of actual or threatened death of a family member or friend, the event(s) must have been violent or accidental.
- d) experiencing repeated or extreme exposure to aversive details of the traumatic event(s) (e.g., first responders collecting human remains, police officers repeatedly exposed to details of child abuse).
 

**Note:** This does not apply to exposure through electronic media, television, movies, or pictures, unless this exposure is work related.

[Source: DSM-5.]

**Burnout** — a cumulative process marked by emotional exhaustion and withdrawal associated with increased workload and organizational stress, (that is not trauma-related) that repeatedly exceeds a workers’ personal stress threshold. [Source: The American Institute of Stress (adapted wording): <https://www.stress.org/military/for-practitionersleaders/compassion-fatigue/>]

**Compassion fatigue** — the physical and mental exhaustion and emotional withdrawal experienced by those that care for sick or traumatized people over an extended period of time. [Source: Medical Dictionary — Merriam-Webster: <https://www.merriam-webster.com/medical/compassion%20fatigue> ]

**Critical event (individual)** — an event or a series of events that has a stressful impact sufficient enough to overwhelm the usually effective coping skills of either an individual or a group.

**Critical event (organization)** — an event or a series of events that interrupts the normal flow of activities of the organization in a way that impacts psychological health and safety.

**Critical incident stress** — any situation faced by emergency service personnel that causes them to experience unusually strong emotional reactions which have the potential to interfere with their ability to function either at the scene or later. [Source: Mitchell (1983).]

**Early intervention program** — a structured, formal program that provides opportunities for workers to receive assistance and support after a critical event or upon early detection of a mental health problem(s).

**Employee assistance program (EAP)** — an employer-sponsored service designed for personal or family problems, including mental health, substance abuse, various addictions, marital problems, parenting problems, emotional problems, or financial or legal concerns. This is typically a service provided by an employer to the employees, designed to assist employees in getting help for these problems so that they may remain on the job and effective.

**Notes:**

- 1) *Employee family assistance program (plan) (EFAP) is a term that is used in some organizations, and many will include service to family.*
- 2) *EAPs commonly employ both regulated and unregulated mental health professionals, who might not meet the specifications outlined in certain regulations such as Bill 163 in Ontario. For this reason, users are recommended to seek clarification from their employer and EAP about the services provided, service providers, and implications for the paramedic service organization.*

[Source: EAP Trade Association, 2016:

<https://www.easna.org/research-and-best-practices/what-is-eap/>]

**Evidence-informed** — the process of distilling and disseminating the best available evidence from research, practice, and experience and using that evidence to inform and improve decision making. [Adapted from National Collaborating Centre for Methods and Tools: <http://www.nccmt.ca/about/eiph>]

**Family** — any combination of two or more persons who are bound together over time by ties of mutual consent, birth, adoption, or placement. [Source: The Vanier Institute of the Family: <http://vanierinstitute.ca/definition-family/>]

**Note:** *Family is inclusive of diverse family structures including (but not limited to) single parents, same-sex couples, stepfamilies, married or common-law couples (with or without children), skip-generation families, and more.*

**Harm** — an injury or damage to health.

**Hazard** — a potential source of psychological harm to a worker. [Source: CAN/CSA-Z1000 (adapted wording).]

**Health** — a state of complete physical, social, and mental well-being, and not merely the absence of disease or infirmity. [Source: World Health Organization Web page <http://www.who.int/suggestions/faq/en/> and BNQ 9700-800]

**Health promotion** — the process of enabling people to increase control over and to improve their health. [Source: *Health Promotion Glossary* and BNQ 9700-800.]

**Mental health** — a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community. Synonym: psychological health. [Source: World Health Organization]

**Note:** *“[...] In this positive sense, mental health is the foundation of well-being and effective functioning for an individual and for a community.” [Source: World Health Organization.]*

**Mental healthcare** — services provided in a community or hospital setting that focuses on maintaining and improving mental health.

**Mental health problems** — spectrum of health concerns that can range from distressing temporary symptoms to a wide range of mental health conditions affecting one’s mood, thinking, behaviour, or physiological responses.

**Operational stress** — the response to an acute event or accumulation of events occurring in the performance of an individual’s operational duties, which could cause them to experience a psychological or physiological stress response.

**Note:** *If these stressors exceed the personal and social resources an individual is able to mobilize, this could pose a risk of developing an operational stress injury (OSI).*

**Operational stress injury (OSI)** — any persistent psychological difficulty resulting from operational duties performed while serving in the paramedic community; the term describes a broad range of problems that include diagnosed psychiatric conditions such as anxiety disorders, depression, and post-traumatic stress disorder (PTSD) as well as other conditions that could be less severe, but still interfere with daily functioning. [Source: Veterans Affairs Canada (adapted wording): <http://www.veterans.gc.ca/eng/services/health/mental-health/understanding-mental-health>.]

**Organization** — a company, employer, operation, undertaking, establishment, enterprise, institution, or association, or a part or combination thereof, that has its own management. [Source: CAN/CSA-Z1000 (adapted wording).]

**Organizational culture** — a pattern of basic assumptions invented, discovered, or developed by a given group that are a mix of values, beliefs, meanings, and expectations that group members hold in common and use as behavioural and problem-solving cues.

**Organizational stress** — the result of those factors in an organization which could cause a worker to experience a psychological or physiological stress response and could in turn have negative organizational consequences. [Source: BMC Public Health (adapted wording): <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3564928/>]

**Paramedic** — a healthcare professional, providing primarily pre-hospital emergency medical assessment and care to individuals with illness or injuries.

**Notes:**

- 1) *In some provinces, hospitals and industrial settings also employ paramedics.*
- 2) *In Canada there are many titles describing the role of a paramedic. The national occupational competency profile for paramedics falls into the following categories:*
  - a) *emergency medical responder (EMR);*
  - b) *primary care paramedic (PCP);*
  - c) *advanced care paramedic (ACP); and*
  - d) *critical care paramedic (CCP).*

*For more information on the national occupational competency profile, see [paramedic.ca](http://paramedic.ca).*
- 3) *The definition of a paramedic can be defined by legislation in certain jurisdictions in Canada. It is the user’s responsibility to determine how applicable legislative requirements relate to this Standard.*

**Paramedic community** — those individuals who directly support the work of a paramedic. This includes

- a) all employees of a paramedic service organization;
- b) those individuals who have a direct impact on the safe and efficient completion of a call; and
- c) those individuals within the identified secondary and tertiary risk groups (see Annex A).

**Paramedic service organization** — an organization or agency providing emergency and non-emergency paramedic care and public safety, including dispatch services, to individuals in the area in which they serve.

**Peer support** — a wide range of approaches wherein participants with shared roles or experiences provide structured assistance to their peers.

**Notes:**

- 1) *Peer support is different from friends providing informal assistance because the peers providing support are typically appropriately trained and potentially supervised in providing mental health support (Grenier et al., 2007; Mead, Hilton, and Curtis, 2001).*
- 2) *Peer support also differs from professional mental healthcare because no power differential is intended between supporters and those supported (Greenstone 2000; Grenier et al., 2007).*
- 3) *See Annex E for further information on the topic of peer support.*

**Post-traumatic stress disorder (PTSD)** — a psychiatric disorder that can occur in people who have experienced or witnessed a traumatic event such as a natural disaster, a serious accident, a terrorist act, war/combat, or rape or other violent personal assault. [Source: American Psychiatric Association: <https://www.psychiatry.org/patients-families/ptsd/what-is-ptsd>]

**Note:** For further information see Annex H.

**Preceptor** — an individual who guides, tutors, and provides direction aimed at a specific performance. [Source: TheFreeDictionary's Medical Dictionary: <https://medical-dictionary.thefreedictionary.com/preceptor>]

**Note:** A preceptor in the paramedic service organization typically assists and supports a new or transferred worker through a planned orientation of the clinical and psychological aspects of the role of paramedic.

**Procedure** — a documented method to carry out an activity. [Source: CAN/CSA-Z1000.]

**Process** — a set of interrelated or interacting activities that transforms inputs into outputs. [Source: CAN/CSA-Z1000.]

**Psychological health** — see **Mental health**.

**Psychological safety** — the absence of harm and/or threat of harm to mental well-being that a worker might experience. [Source: Guarding Minds@Work (adapted wording).]

**Note:** *Improving the psychological safety of a work setting involves taking precautions to avert injury or danger to worker psychological health.*

**Psychologically healthy and safe workplace** — a workplace that promotes workers' psychological well-being and actively works to prevent harm to worker psychological health including in negligent, reckless, or intentional ways. [Source: Guarding Minds@Work (adapted wording).]

**Psychosocial risk factor** — hazards including elements of the work environment, management practices, and/or organizational dimensions that increase the risk to health.

**Regulated mental health professional** — person who offers services for the purpose of improving an individual's mental health or to treat mental disorders and who is part of a profession recognized through a government Act as having the capacity to be accredited by and accountable to a governing college.

**Notes:**

- 1) *Regulated or licensed mental health professionals are governed under a legislative framework that establishes health regulatory colleges that regulate in the public interest.*
- 2) *Health regulatory colleges are responsible for ensuring that regulated mental health professionals provide mental health services in a safe, professional, and ethical manner.*
- 3) *See Annex G for additional information.*

**Risk** — the combination of the likelihood of the occurrence of harm and the severity of that harm. [Source: CSA Z1002.]

**Risk analysis** — the systematic use of information to identify hazards and to estimate the risk.

**Notes:**

- 1) *Risk analysis provides a basis for risk evaluation and risk control.*
- 2) *Information can include current and historical data, theoretical analysis, informed opinions, and the concerns of stakeholders.*

**Risk assessment** — the overall process of risk analysis and risk evaluation.

**Risk criteria** — terms of reference by which the significance of risk is assessed.

**Note:** *Risk criteria can include associated cost and benefits, legal and statutory requirements, socioeconomic and environmental aspects, the concerns of stakeholders, priorities, and other inputs to the assessment.*

**Risk evaluation** — the process of comparing the estimated risk against given risk criteria to determine the significance of the risk.

**Senior management** — the person(s) at the highest level of an organizational structure responsible for leading, managing, and/or directing an organization.

**Stakeholder** — any person or organization within the workplace that can affect or be affected by, or perceive themselves to be affected by, the decisions or activities related to mental health and safety factors within the workplace. [Source: ISO Guide 73, Paragraph 3.2.1.1.]

**Trauma** — a single event or cumulative exposure to death, threatened death, actual or threatened serious injury, or actual or threatened sexual violence in the following ways:

- a) direct exposure;
- b) witnessing;
- c) learning that a relative or close friend was exposed to a trauma; or
- d) indirect exposure to aversive details of the trauma, usually in the course of professional duties.

**Worker** — a person employed by an organization or a person under the day-to-day control of the organization, whether paid or unpaid, which includes employees, supervisors, managers, leaders, contractors, service providers, volunteers, students, or other stakeholders actively engaged in undertaking activities for benefit to the organization. [Source: CAN/CSA-Z1000 (adapted wording).]

**Worker representative** — a non-managerial worker who is

- a) a member of the workplace health and safety committee;
- b) a representative of other workers in accordance with the requirements of law or collective agreements; or
- c) selected by non-managerial workers for other reasons.

**Workplace** — an area or location where a worker works for an organization, or is required or permitted to be present while engaging in service (including social events) on behalf of an organization.

### 3.2 Abbreviations

The following abbreviations are used in this Standard.

- ACP — advanced care paramedic  
 CIS — critical incident services  
 CCP — critical care paramedic



EAP	— employee assistance program
EFAP	— employee and family assistance plan
EMR	— emergency medical responder
EMS	— emergency medical service
LTD	— long term disability
OHS	— occupational health and safety
OSI	— operational stress injury
PCP	— primary care paramedic
PHSMS	— psychological health and safety management system
PPE	— personal protective equipment
PPHS	— paramedic psychological health and safety
PTSD	— post-traumatic stress disorder
ROSC	— return of spontaneous circulation
RTW	— return to work
SAW	— stay at work
STD	— short term disability

## 4 Psychological health and safety management system

### 4.1 General

The organization shall establish, document, implement, and maintain a psychological health and safety management system (PHSMS) in the workplace and continually improve its effectiveness in accordance with the requirements of this Standard.

This PHSMS should be integrated into, or compatible with, governance practices and other systems in the organization.

The PHSMS includes the following elements:

- a) commitment, leadership, and participation (see Clause 4.2);
- b) planning (see Clause 4.3);
- c) implementation (see Clause 4.4);
- d) evaluation and corrective action (see Clause 4.5); and
- e) management review (see Clause 5).

### 4.2 Commitment, leadership, and participation

#### 4.2.1 General

Commitment, leadership, and effective participation are crucial to the success of the PHSMS. All stakeholders share an interest and responsibility to ensure psychological health and safety in the workplace.

Management shall ensure that the responsibilities and authorities related to the PHSMS are defined and communicated throughout the organization.

**P** The following applies to paramedic service organizations:

Paramedic service organizations should ensure that programs for assisting with the psychological health and safety of workers are available and accessible. Every effort should be made to remove organizational and operational barriers and financial impacts to the worker.

#### 4.2.2 Commitment

The organization shall have or incorporate into existing policies a current policy statement approved by senior management and the Board of Directors (where applicable) that outlines their commitment to the development of a systematic approach for managing psychological health and safety in the workplace. The policy statement shall be based on the organizational commitments to

- a) establish, promote, and maintain a PHSMS in accordance with this Standard;
- b) align with the ethics and stated values of the organization;
- c) establish and implement a process to evaluate the effectiveness of the system and implement changes as necessary;
- d) delegate the authority necessary to implement an effective system;
- e) ensure that workers and worker representatives, as required, participate in the development and implementation and continual improvement of the system;
- f) provide the required resources to develop, implement, and maintain the PHSMS;
- g) evaluate and review the system at planned intervals for the purpose of continual improvement; and
- h) recognize that it is in everybody's common interest to promote and enhance a working relationship consistent with the principles of mutual respect, confidentiality, and cooperation.

**P** The following applies to paramedic service organizations:

For paramedic service organizations, a policy statement may be in the form of commitment statements or guiding principles.

#### 4.2.3 Leadership

This Clause pertains to those who have key responsibility for the organization's performance. People in leadership roles shall

- a) reinforce the development and sustainability of a psychologically healthy and safe workplace environment based on a foundation of ethics and stated values;
- b) support and reinforce all line management in the implementation of the PHSMS;
- c) establish key objectives toward continual improvement of psychological health and safety in the workplace;
- d) lead and influence organizational culture in a positive way (see Annex J for resources);
- e) ensure that psychological health and safety is part of organizational decision making processes;
- f) engage workers and, where required, their representatives to
  - i) be aware of the importance of psychological health and safety;
  - ii) be aware of the implications of tolerating psychological health and safety hazards;
  - iii) provide feedback to help the organization determine the effectiveness of the PHSMS implementation and operation; and
  - iv) identify workplace needs regarding psychological health and safety.

**P** The following applies to paramedic service organizations:

People in leadership roles within a paramedic service organization shall recognize that families and external support systems of workers are integral to the ability of a worker to cope with operational stressors and stress injuries, and shall be considered through all applicable aspects of the PHSMS.

## 4.2.4 Participation

### 4.2.4.1

Active, meaningful, and effective participation of stakeholders is a key factor in psychological health. Participation is a requirement for successful policy development, planning, implementation, and operation of specific programs, and evaluation of the system and its impacts. To ensure such participation, the organization shall

- a) engage stakeholders in active regular dialogue that facilitates understanding of stakeholders' needs and goals;
- b) engage workers and, where required, their representatives in policy development, data gathering, and the planning process to better understand their needs with respect to psychological health and safety in the workplace;
- c) encourage workers and, where required, their representatives to participate in programs implemented to meet identified needs;
- d) actively involve workers and, where required, their representatives in the evaluation process through the use of recognized instruments such as focus groups, surveys, and audits; and
- e) ensure that the results generated by the evaluation process and the follow-up plans of action are effectively communicated with all management, workers, and their representatives (where applicable).

The organization shall engage the Occupational Health and Safety (OHS) committee or HS representatives, where required, to define their involvement in the PHSMS. Where discussion of psychological hazards in the workplace takes place at the OHS committee, confidentiality of all persons shall be respected and identifying markers removed from the documents used at the OHS committee in accordance with Clause 4.2.5.

To further encourage participation and engagement, the organization may consider the implementation of a specific committee or sub-committee for psychological health and safety in the workplace.

**P** The following applies to paramedic service organizations:

All individuals within a paramedic service organization should recognize that families and external support systems of workers are integral to the ability of a worker to cope with operational stressors and stress injuries and need to be considered through all applicable aspects of the PHSMS.

### 4.2.4.2

Worker participation is an essential aspect of the PHSMS in the organization. The organization shall

- a) provide workers and worker representatives with time and resources to participate effectively in the development of the psychological health and safety policy and in the process of PHSMS planning, implementation, training, evaluation, and corrective action; and
- b) encourage worker participation by providing mechanisms that
  - i) support worker participation, such as identifying and removing barriers to participation;
  - ii) establish workplace health and safety committees or worker representatives where required by OHS legislation and, where applicable, collective agreements or other requirements; and

- iii) ensure that workers and worker representatives are trained in, and consulted on, all aspects of PHSMS associated with their role within this system.

**Note:** Consultation with workers and worker representatives does not require the organization to obtain worker approval or permission. Worker and worker representative participation should not interfere with business needs or operations.

#### 4.2.5 Confidentiality

The organization shall establish and sustain processes that ensure confidentiality and privacy rights are respected and protected.

**P** The following applies to paramedic service organizations:

The paramedic service organization shall

- a) establish, implement, and sustain policies, programs, and processes that ensure confidentiality and privacy rights are respected and protected within the applicable territorial, provincial, and federal legislation;
- b) respect a worker's request to release his/her personal health information in the organization's custody; and
- c) ensure that confidentiality is maintained for any internal or external auditing personnel.

Stigma and organizational culture issues regarding psychological injuries and mental health problems are known to be a significant barrier to workers reporting psychological injuries and accessing care. Maintaining confidentiality is an essential element of a successful PHSMS (see Annex C for additional information on confidentiality).

##### Storage of personal health information

The paramedic service organization shall not have the ability (real or perceived) to access the workers' confidential health information without informed written consent.

The collection, storage, maintenance, disclosure, and destruction of confidential health information shall meet or exceed the applicable territorial, provincial, and federal confidentiality and privacy legislation.

### 4.3 Planning

#### 4.3.1 General

Planning enables an organization to identify and prioritize work-related psychological health and safety

- a) hazards;
- b) risks;
- c) legal requirements;
- d) management system gaps; and
- e) opportunities for improvement.

The planning process is necessary to establish appropriate objectives and targets, and plans to achieve compliance with legal requirements, relevant regulations, organizational requirements, and a commitment to continual improvement.

### 4.3.2 Planning process

The planning process shall include

- a) planning for management of psychological health and safety in the workplace, including the assessment of worker health impact, financial impact, and organizational policy and processes that promote good psychological health;
- b) developing a collective vision of a psychologically healthy workplace, specific goals for reaching the vision, and a plan for ongoing process monitoring for continual improvement;
- c) assessment of the strengths of the existing psychological health and safety strategy; and
- d) recognition and identification of current practices that are already protecting and promoting psychological health and safety.

**P** The following applies to paramedic service organizations:

#### Return-to-work and stay-at-work programs

As part of the planning process, the organization shall review its workplace policies and procedures on return-to-work and stay-at-work.

The organization shall develop, implement, and maintain an individualized and flexible return-to-work and stay-at-work program as part of the PHSMS, in conjunction with any territorial, provincial, and federal regulation and legislation, and any applicable employment contracts.

The following steps shall be incorporated within the organization's return to work program and stay at work program:

- a) development of a worker-centered return-to-work and stay-at-work plan; the plan shall be
  - i) individualized according to restrictions, accommodation, limitations, and abilities; and
  - ii) flexible, graduated, and modifiable;
- b) scheduling of regular follow-up meetings, to review the progress of the worker and ensure that plans are put into place that meet the needs of the individual, and that the plans are modified accordingly;
- c) assist and support with return-to-practice assessment with an occupational competency evaluation, including continuing medical education (CME) sessions, certification renewal, reactivation, and initiation;
- d) supporting workers by openly and clearly communicating with them about any income variances they might encounter throughout the return-to-work and stay-at-work process; and
- e) sharing the return-to-work and stay-at-work policies and processes with workers throughout their career.

**Note:** *This can inform workers how the process works, and normalize the idea of looking for support if they are struggling.*

In addition, all levels of management and worker representatives should receive training in accommodations and return to work strategies, which should include leadership competencies to improve communication with, and supports to, all staff.

**Note:** *See Annex F for additional information on return-to-work and stay-at-work programs.*

### 4.3.3 Review

The organization shall review its approach to managing and promoting psychological health and safety in the workplace, to assess conformance with the requirements and recommendations in this Standard. If no such system exists, the organization shall establish a system in conformance with this Standard.

### 4.3.4 Identification, assessment, and control

**P** The following applies to paramedic service organizations:

**Note:** *Paramedic service organizations should also consider a set of very specific factors that are listed in Annex B.*

#### 4.3.4.1

The organization shall develop, implement, and maintain a documented risk mitigation process that includes

- a) hazard identification;
- b) elimination of those hazards that can be eliminated;
- c) assessment for level of risk for hazards that cannot be eliminated;
- d) preventive and protective measures used to eliminate identified hazards and control risks; and
- e) a priority process reflecting the size, nature, and complexity of the hazard and risk, and, where possible, respecting the traditional hierarchy of risk control.

**Notes:**

- 1) *The hierarchy of risk control can involve the following:*
  - a) *elimination of the hazard;*
  - b) *control the risk or control access to the hazards;*
  - c) *substitution of the hazard with something less hazardous;*
  - d) *making changes to how the work is organized and done;*
  - e) *modifying procedures and practices;*
  - f) *administrative/training;*
  - g) *protective equipment; and*
  - h) *emergency response plans.*
- 2) *The documentation can be scaled to the size, nature, and complexity of the organization.*

**P** The following applies to paramedic service organizations:

**Note:** *This Standard addresses psychological hazards in accordance with best practice in terms of risk assessment, hazard control, and continual improvement. The purpose of a risk mitigation process is to identify all the potential workplace hazards and to estimate and assess their risk to the workers. Preventive and protective measures are intended to either eliminate or effectively mitigate (reduce and control) the level of risk to the workers. The hierarchy of intervention effectiveness recommends both person-based and system-based interventions.*

#### 4.3.4.2

Factors to assess should include, but are not limited to, the following:

- a) psychological support;
- b) organizational culture;
- c) clear leadership and expectations;
- d) civility and respect;
- e) psychological job demands;
- f) growth and development;
- g) recognition and reward;
- h) involvement and influence;
- i) workload management;
- j) engagement;
- k) work/life balance;
- l) psychological protection from violence, bullying, and harassment;
- m) protection of physical safety; and

n) other chronic stressors as identified by workers.

**Notes:**

- 1) *A description of these factors is included in Annex B.*
- 2) *Resources such as GuardingMinds@Work (GM@W) can provide a first step to assessing these factors.*

In addition to assessing risks, the organization should identify and assess opportunities for promoting psychological health.

**P** The following applies to paramedic service organizations:

The paramedic service organization should assess chronic/cumulative exposure to critical/stressful events.

**Notes:**

- 1) *Paramedic service organizations should pay particular attention to the assessment of organizational culture due to the potential impact on, and contributions to, the psychological well-being of workers in paramedic service organizations.*
- 2) *See Annex B.*

#### 4.3.5 Data collection

The organization shall establish a data gathering process using qualitative, quantitative, or mixed methods. The degree of detail required will depend upon the complexity of the workplace, the goals of the PHSMS, the reasonable accessibility of reliable data, and the decision-making needs of the organization. Any collection of data shall comply with all privacy requirements, legislation, collective agreements, and policies.

The organization shall keep a record of the data collected and of the methods used in data collection. Where required by regulation, the organization shall share the data collected and related reports with the OHS committee. Where data is shared, confidentiality of all persons shall be respected and identifying markers removed from the documents in accordance with Clause 4.2.5.

Data sources and reference documents may include

- a) existing organizational policies and plans pertinent to psychological health and safety in the workplace;
- b) job descriptions/job demands analysis;
- c) aggregated administrative data, such as
  - i) rates of absenteeism;
  - ii) rates of turnover;
  - iii) return-to-work and accommodation data;
  - iv) short-term disability (STD) and long-term disability (LTD) costs;
  - v) employee and family assistance plan (EFAP);
  - vi) principal diagnostic categories (for short term disabilities/long term disabilities);
  - vii) claims data such as benefit utilisation rates, disability relapse rates, and workers compensation data;
  - viii) review of incident reports/worker complaints/investigations; and
  - ix) health risk assessment data;
- d) laws and regulations, including
  - i) human rights;
  - ii) OHS acts;
  - iii) violence and abuse prevention in the workplace;
  - iv) labour laws; and

- v) workers compensation;
- e) standards, codes, and guidelines;
- f) worker engagement indicators and worker feedback (e.g., surveys, participation rates);
- g) report(s) from unions or worker groups regarding exposure/risk information;
- h) diverse perspectives (e.g., mental illness, cultural differences), including those with personal experience of mental health issues, various cultures, etc.;
- i) results of organizational audit;
- j) industry or association established best practices; and
- k) research.

**P** The following applies to paramedic service organizations:

Data sources for paramedic service organizations may also include

- a) call volume;
- b) call demographics (e.g., call type including attempted and suicides in the patient community, level of patient acuity, times, location, patient disposition);
- c) patient demographics (e.g., age, gender, pick-up location);
- d) demographics of the paramedic service organization employees (e.g., years of service, age at retirement and percentage of employees who continue working in the field to retirement, diversity of the workforce etc.);
- e) prevalence data of OSI;
- f) suicides within the paramedic community, including psychological post-mortem documentation for suspected or confirmed suicides;
- g) number, availability, and type of interventions and other support programs;
- h) utilization rates for peer support groups;
- i) utilization rates for organizational wellness programs; and
- j) collecting data (i.e., number of participants) regarding mental health training citing data (i.e., how many workers have participated) and measuring the impact of training through follow-up measures (i.e., surveys).

The purpose of collecting and monitoring data is to allow a means for the organization to review, to plan for change, to implement changes, and to evaluate the effectiveness of the changes as necessary.

**Notes:**

- 1) *There is a risk to worker engagement and participation with the PHSMS programs and initiatives by creating secondary stressors if there is misuse of aggregate data, such as implementing intrusive or disciplinary measures.*
- 2) *Sharing of anonymized or aggregate information between and across paramedic service organizations with comparable data points and standardized measures could improve service delivery and potentially assist in reducing operational stress injuries.*

**System for data collection**

Paramedic service organizations shall implement a system for data collection to track worker exposure to trauma over time to help identify workers at risk. This system should include

- a) tracking of exposure to critical events and potentially traumatic events;

**Note:** *The collection of critical event data generally provides only a glimpse into possible increased stress/strain on the worker. It is difficult to know exactly what type of event could be considered a significant event as there are many variables. Self-reporting should be taken into consideration in this process.*



- b) system for early identification of worker needs and engagement to the appropriate mental health resources, both formal and informal (e.g., peer support, wellness checks, EFAP, supervisor contact); and
- c) information to workers on how their privacy is maintained within the system.

### 4.3.6 Diversity

Organizations comprise diverse populations and groups.

The organization shall consider the unique needs of these diverse populations and solicit input when these needs are relevant to complying with the requirements of this Standard.

The organization shall consider workplace factors that can impact the ability of these workers to stay at work or return to work.

While psychological health and safety in the workplace is a shared responsibility among stakeholders, the organization should support individual workers to seek assistance internally or externally when needed.

The organization shall take steps to link workers in need to internal resources and should also take steps to link workers to community or other resources.

**P** The following applies to paramedic service organizations:

*Note: Programs and services offered to support staff should accommodate, respect, and be representative of the organization's diverse population.*

### 4.3.7 Objectives and targets

#### 4.3.7.1

The organization shall document the psychological health and safety objectives and targets for relevant functions and levels within the organization. The objectives and targets should be

- a) measurable;
- b) consistent with the psychological health and safety policy and commitment to the PHSMS, compliance with legal requirements and other requirements, and commitment to continual improvement;
- c) based on past reviews, including past performance measures and any psychological health and safety hazards, risks, the results of the data collection (see Clause 4.3.5) and identification and assessment of psychological workplace factors (see Clause 4.3.4), management system deficiencies, and opportunities for improvement that have been identified;
- d) determined after consultation with workers and with consideration of technological options and the organization's operational and business requirements; and
- e) reviewed and modified according to changing information and conditions, as appropriate.

The organization should consider objectives and targets that reinforce existing strengths and promote new opportunities for improving psychological health and safety.

#### 4.3.7.2

The organization shall establish and maintain a plan for achieving its objectives and targets. The plan shall include

- a) the designation of responsibility for achieving objectives and targets; and

- b) identification of the means and time frame within which the objectives and targets are to be achieved.

### 4.3.8 Managing change

**P** The following applies to paramedic service organizations:

**Note:** *Change management strategies should include communications to appropriate paramedic community stakeholders.*

If training or support is required regarding management of change activities, care should be taken to ensure the supervisors and managers are included within these activities. As applicable, managers and supervisors should be given the opportunity to receive such information in advance of their staff.

#### 4.3.8.1

The organization shall establish, implement, and maintain a system to manage changes that can affect psychological health and safety. The system shall address changes that include

- a) new products, processes, or services at the design stage;
- b) significant changes to work procedures, equipment, organizational structure, staffing, products, services, or suppliers;
- c) changes to psychological health and safety strategies and practices;
- d) changes to psychological health and safety legal and other requirements; and
- e) changes to work arrangements, including modified work arrangements.

#### 4.3.8.2

Such a system should include

- a) communication between stakeholders about the changes;
- b) information sessions and training for workers and worker representatives; and
- c) support as necessary to assist workers in adapting to changes.

## 4.4 Implementation

### 4.4.1 Infrastructure and resources

The organization shall provide and sustain the infrastructure and resources needed to achieve conformity with this Standard.

The following should be taken into consideration:

- a) workplace parties should possess sufficient authority and resources to fulfill their duties related to this Standard;
- b) workplace parties should possess the knowledge, authority, and abilities to integrate psychological health and safety into management systems, operations, processes, procedures, and practices; and
- c) persons with roles as specified in this Standard should possess the knowledge, skills, and abilities to carry out their roles (e.g., auditing, training, assessment, analysis).

**Note:** *Internal or external resources might be able to provide substantial expertise, proven programs, or assistance in implementing psychological health and safety programs in the workplace.*

**P** The following applies to paramedic service organizations:

The paramedic service organization may utilize internal or external mental health services where there is a quality assurance process for the mental health professional's performance (internal or external).

#### 4.4.2 Preventive and protective measures

The organization shall establish and sustain processes to implement preventive and protective measures to address the identified work-related hazards and risks.

Preventive and protective measures should be implemented according to the following priority:

- a) eliminate the hazard;
- b) implement controls to reduce the risks related to hazards that cannot be eliminated;
- c) implement use of personal protective equipment (PPE) in applicable circumstances;
 

**Note:** *The key is to recognize and consider PPE requirements in the context of both physical and psychological safety. Some examples of PPE related to psychological safety could include personal alarm devices or privacy barriers.*
- d) implement processes to respond to issues that can impact psychological health and safety of workers; and
- e) offer resources to workers who are experiencing mental health difficulties, whether these difficulties relate to organizational factors or to other factors, such as personal factors.
 

**Note:** *These resources could be found within the organization, in the public domain, online, or in the community.*

#### **P** The following applies to paramedic service organizations:

The paramedic service organization shall establish and sustain processes for preventive, evidence-informed workplace interventions and ensure these interventions are available to all workers. These workplace interventions should include

- a) monitoring exposure to trauma and chronic stressors;
- b) system for early identification of worker needs and engagement to the appropriate mental health resources, both formal and informal (e.g., referral to mental health professional, peer support, wellness checks, EFAP, supervisor contact);
 

**Note:** *There is a risk of secondary stress to a worker if the prevention system interventions are not coordinated and repeated contact is initiated after a worker has declined to participate.*
- c) orientation for new workers including mental health awareness and training;
- d) programs to build and strengthen resiliency skills;
- e) proactive outreach to those who might exhibit concerning changes in behaviour;
- f) peer support programs (see Annex H);
- g) post-trauma support (early and ongoing); and
- h) self-care promotion and support (work-life balance, nutrition, fitness, etc.).

**Note:** *Paramedic service organizations should consider establishing relationships or partnerships with local paramedic training institutions or organizations to promote processes for preventive, evidence-informed interventions to be taught at the educational program level as applicable. The hierarchy of intervention effectiveness recommends both person-based and system-based interventions.*

#### Psychological health and safety awareness and stigma reduction

The stigma associated with mental health difficulties and challenges can deter workers from seeking assistance at the earliest possible opportunity. Many stigma reducing initiatives are not costly to implement and can be very effective.

The paramedic service organization shall develop, implement, and maintain an evidence-informed psychological health and safety awareness and stigma reduction program including acceptable workplace behaviours. The paramedic service organization shall ensure all workers are provided with psychological health and safety awareness and stigma reduction training and education.

Some actions that may be considered in developing of a program include

- a) demonstrating support for stay-at-work or return-to-work programs and activities;
- b) regularly updating staff on what the organization is doing to reduce stigma and raising awareness on psychological health and safety;
- c) promoting participation in psychological health and safety campaigns;
- d) mental health literacy awareness and training;
- e) allowing workers and their families opportunities for sharing constructive personal mental health experiences;
- f) encouraging all levels of management to actively endorse and participate in psychological health and safety promotion activities;
- g) including family members and key stakeholders in communications about PHS initiatives and services, where appropriate; and
- h) including information about accessing services for family members.

**Note:** *Elements of this program might already be in existence within some organizations' respectful workplace or bullying policies, procedures, or programs.*

### Psychological wellness check

**Note:** *This section is based on material that has been adapted with permission from Dunlap, Couperthwaite and Lee, 2017 (CAMH).*

A psychological wellness check process can provide a baseline, as well as allowing for a confidential discussion between workers and a regulated mental health professional about the nature of the work and potential psychological risks, an assessment and discussion regarding individual vulnerabilities, treatment recommendations if warranted, and recommendations for skill building (e.g., self-care strategies, stress management techniques).

The paramedic service organization should establish, implement, and maintain a psychological wellness check process for all identified at risk workers.

The psychological wellness check process should be

- a) easily accessible to workers as applicable;
- b) conducted by a regulated mental health professional (see annex G);
- c) carried out upon entry to work to provide a baseline; and
- d) carried out as a regular follow-up to assess coping skills and strategies and to encourage positive mental health.

#### Notes:

- 1) *The intent of a baseline wellness check is to provide a starting point for the purposes of worker self-development.*
- 2) *The psychological wellness check may be incorporated as part of an overall health and wellness check.*

### Identify and strengthen protective factors

In addition to the identification of hazards and risk factors, paramedic service organizations should identify and strengthen protective factors, such as

- a) sense of community: feelings of belonging or emotional attachment by identifying, establishing, and maintaining acceptable behaviours that are supportive and inclusive of a psychologically healthy and safe workplace;

- b) collective efficacy: perception of a group's ability to achieve intended objectives;
- c) self-efficacy: perception of an individual's ability to achieve intended objectives;
- d) positive coping strategies: ability to constructively manage stress; and
- e) compassion satisfaction: positive feelings from helping someone and feeling valued.

#### **Suicide awareness and prevention**

The paramedic service organization shall develop, implement, and maintain an evidence-informed suicide awareness, prevention, intervention, and post-vention program integrated within the PHSMS.

#### **4.4.3 Education, awareness, and communication**

The organization shall establish and sustain processes to

- a) provide information about factors in the workplace that contribute to psychological health and safety, and specifically how to reduce hazards and risks that potentially cause psychological harm and how to enhance factors that promote psychological health;
- b) ensure stakeholder education, awareness, and understanding in regards to the nature and dynamics of stigma, psychological illness, safety, and health;
- c) communicate to stakeholders existing policies and available supports;
- d) communicate to stakeholders processes available when issues can impact psychological health and safety;
- e) communicate to stakeholders information about the psychological health and safety system and related plans and processes;
- f) include stakeholder ideas, concerns, and input for consideration; and
- g) ensure communication throughout the monitoring and review process (see Clause 4.5) to all workplace parties.

#### **P The following applies to paramedic service organizations:**

The paramedic service organization shall encourage and support workers in recognizing their responsibilities for maintaining their own psychological health and positively contributing to the well-being of those around them.

#### **Stages of employment**

Paramedic service organizations shall ensure that psychological health and safety education and training opportunities are made available to workers throughout all stages of employment, from the recruitment stage through retirement.

#### **Families**

Paramedic service organizations shall provide access to information regarding mental health to the families of workers. This information shall include

- a) early warning signs of potential operational stress injuries; and
- b) mental health resources that are available to workers and families of workers and how they can be accessed (e.g., through a website or pamphlet).

Communication regarding psychological health and safety initiatives should be extended to families of workers. The organization should consider making opportunities for mental health education and training available to families.

#### 4.4.4 Sponsorship, engagement, and change management

The organization shall establish processes that support effective and sustained implementation, including

- a) sponsorship by senior leadership and leadership at all levels of the organization;
- b) engagement on the part of stakeholders; and
- c) assessment and application of change management principles throughout planning and implementation.

**P** The following applies to paramedic service organizations:

**Note:** *Workers should be the priority when referring to stakeholders.*

#### 4.4.5 Implementation governance

The organization shall establish

- a) clear responsibilities and accountabilities for effective implementation;
- b) governance processes that support effective implementation and communication plans; and
- c) documentation requirements.

**P** The following applies to paramedic service organizations:

Governance means establishing a clear and systematic methodology for implementation. It is critical when making change in an organization to clearly define who in the organization will be responsible for the implementation, how the organization will measure and document the effectiveness of the PHSMS, and how this will be communicated to workers. Senior management has a strong role to play in implementation governance in ensuring resources and infrastructure are adequate and that the workforce is involved and engaged. See Clause 4.2.3 on leadership.

#### 4.4.6 Competence and training

**P** The following applies to paramedic service organizations:

Paramedic service organizations shall provide mental health education and training programs that

- a) are evidence-informed;
- b) provide new workers with a comprehensive preview of what they can expect on the job and how it might affect them;
- c) have regularly scheduled training on psychological health and safety and offer refreshers;
- d) provide continuing education related to the signs and symptoms of OSIs;
- e) incorporate mandatory and optional training that includes knowledge application and skill building;
- f) provide training and education on psychological health and safety that is appropriate to the different stages of careers; and
- g) provide new managers with training and opportunities for further development on PHS.

All psychological health and safety training programs shall have feedback systems for continual quality assurance and improvement.

##### 4.4.6.1

The organization shall establish and sustain processes to

- a) determine expectations and minimum requirements of workers and, in particular, those in leadership roles (e.g., supervisors, managers, worker representatives, union leadership) to prevent

- psychological harm, promote psychological health of workers, and address problems related to psychological health and safety; and
- b) provide orientation and training to meet Item a).

**P** The following applies to paramedic service organizations:

Workers and managers should receive training that informs, builds competencies and skills, and promotes overall psychological health and safety in a workplace context. Training in areas including, but not limited to, the following should be considered within a PPHSMS:

- a) general:
- i) psychological health and safety awareness;
  - ii) confidentiality of the program(s) (see Annex C); and
  - iii) services and programs available to support PPHS and overall goals of the organization in relationship to PHS;
- b) crisis management:
- i) suicide awareness;
  - ii) information regarding the organization's suicide prevention programming, including processes and procedures for high risk situations;
  - iii) what to do if a worker is exhibiting signs of decreased psychological health (e.g., how to access the prevention program); and
  - iv) options for acute and post trauma support, and education about the different processes and functions, including pros and cons of each;
- c) mental health problem awareness and prevention:
- i) stigma reduction (see "Psychological health and safety awareness and stigma reduction" in Clause 4.4.2);
  - ii) common types of operational stress injuries and their symptoms;
  - iii) what therapy has to offer, options for mental health services, and differences between types of mental health professionals and services offered; and
  - iv) working with patients with various types of mental health problems, use of psychotropic medications, and their uses/side effects/withdrawal effects/contraindications;
- d) mental health promotion:
- i) resilience and application of skills learned;
  - ii) capacity building/mental health in the workplace;
  - iii) self-care strategies; and
  - iv) training for continuing to build informal support (e.g., education about the importance of social support on well-being, interpersonal skill development); and
- e) conflict management skills:
- i) information aimed at increasing one's emotional intelligence;
  - ii) learning skills to respond to challenging situations;
  - iii) conflict resolution and de-escalation;
  - iv) mental health education and training to assist the public who are in distress; and
  - v) self-defense (should be combined with de-escalation to incorporate self-protection skills).

Organizations should consider providing train-the-trainer opportunities to workers in order to have training delivered by those familiar with the paramedic community.

In collaboration with the educational institutions as applicable, the paramedic service organization

should provide additional training and awareness to those individuals taking on the role of mentor or preceptor to assist in the protection of the psychological health and safety of workers.

**Note:** *The concept of first-time exposure is a unique element typically addressed by those in the role of mentor or preceptor.*

The paramedic service organization should have a process to support the transfer of skills, knowledge, and attitudes into the workplace in the area of stigma reduction.

See CAN/CSA-Z1001 for further information and guidance in the area of occupational health and safety training.

#### 4.4.6.2

The organization should establish and sustain processes to

- a) provide accessible coaching and supports as required, recognizing the potential complexities of psychological health and safety situations, the unique needs of the individuals affected, and the skills needed; and
- b) assess and address competence as specified in Clause 4.4.6.1, Item a) of those in leadership roles.

#### 4.4.7 Critical event preparedness — Individual(s)

The organization shall establish and sustain processes to

- a) identify potential critical events where psychological suffering, illness, or injury is involved, or likely to occur, while respecting confidentiality and privacy of all parties;
- b) provide response and support, including consideration of specialized external supports;
- c) provide related training for key personnel involved in critical event response; and
- d) ensure there are opportunities for debriefing and for revising guidelines for critical events as applicable.

**Note:** *The purpose of this Clause is to help workers who might be dealing with incidents within or external to the workplace (e.g., bullying, harassment, death of a family member).*

**P** The following applies to paramedic service organizations:

Paramedics encounter critical events on a more frequent basis than many worker groups.

Paramedic service organizations shall be prepared with critical event response plans. These response plans shall be communicated and accessible in advance to all parties within the organization.

Paramedic service organizations shall ensure that psychological health and safety support is included in the development of the individual and organizational critical plans.

**Note:** *Participatory planning is encouraged to ensure the critical event planning process reflects the individual worker and workplace needs.*

#### Factors and stressors contributing to individual critical events

Paramedic service organizations shall consider factors and stressors that are both internal and external to the workplace that can contribute to stronger individual responses to individual critical events.

The individual critical event process should also include

- a) how the critical event process is activated;
- b) how the organization will ensure a worker-focused response; and



- c) consideration for reactions to atypical events and repeat exposures.

This process should be developed and maintained in collaboration with a subject matter expert.

To complement critical event support initiatives offered internally by the organization, paramedic service organizations should consider providing an option for workers to access independent, external support.

**Note:** *It is difficult to know exactly what type of event could be considered a significant event as there are many variables. Self-reporting should be taken into consideration in this process.*

In the paramedic service organization, the term “critical incident” is often used to describe an individual critical event.

Examples of individual critical events within a paramedic service organization might be the death of a co-worker, death of an infant, injury to a spouse or significant other, exposure to an infectious agent or parasite.

Not all critical events will impact individuals in the same manner. What makes an event critical for an individual is based on many factors, some of which could be specific to the individual (e.g., values; beliefs; personal experiences; and current state of wellness).

#### 4.4.8 Critical event preparedness — Organization

Organizations might undertake or experience events that pose particular risks or are likely to have particular impacts on psychological health and safety. The organization shall establish and sustain processes to

- a) ensure the psychological health and safety risks and impacts of critical events are assessed;
- b) manage critical events in a manner that reduces psychological risks to the extent possible and supports ongoing psychological safety;
- c) incorporate learning from critical events into established plans related to the psychological health and safety system; and
- d) ensure there are opportunities for reviewing and for revising guidelines for critical events as applicable.

**P** The following applies to paramedic service organizations:

The paramedic service organization shall ensure that psychological health and safety support is included in the development of their emergency plans.

Paramedic service organizations should consider psychological health and safety mutual aid agreement(s) for extraordinary events.

**Notes:**

- 1) *The purpose of this Clause is to identify the organization’s role in critical event preparedness including learning from past events.*
- 2) *Critical events impacting at an organizational level are highly variable.*

#### 4.4.9 Reporting and investigations

**P** The following applies to paramedic service organizations:

**Note:** *Paramedic service organizations should consider participating in external reporting systems (consisting of de-individualized aggregate data) developed to identify work-related psychological health and safety trends and learning.*

#### 4.4.9.1

The organization shall establish and maintain procedures for reporting and investigating work-related psychological health and safety incidents such as psychological injuries, illnesses, acute traumatic events, fatalities (including suicides), and attempted suicides.

Such investigations should be carried out by persons who are experienced in psychological injury and incident investigation and who are impartial (and are perceived to be impartial by all parties), and should be carried out with the participation of the appropriate workplace parties, respecting the privacy and confidentiality of involved parties and other relevant legislation.

These procedures shall include

- a) the establishment of roles and responsibilities of all parties participating in the investigation process;
- b) practices that foster a psychologically safe environment that allows workers to report errors, hazards, adverse events, and close calls;
- c) a commitment to appropriate accountability, looking first at system factors that contributed to the error or adverse event;
- d) actions to mitigate any consequences of work-related psychological injuries, illnesses, acute traumatic events, chronic stressors, fatalities (including suicides), attempted suicides, and psychological health and safety incidents;
- e) the identification of the immediate and underlying cause(s) of such incidents and the implementation of recommended corrective and preventive actions; and
- f) an assessment of effectiveness of any preventive and corrective actions taken.

#### 4.4.9.2

The investigation of cause(s) of work-related psychological health and safety incidents such as psychological injuries, illnesses, acute traumatic events, psychosocial risk factors, fatalities (including suicides), and attempted suicides, shall include the identification of any failures in the PHSMS and shall be documented.

#### 4.4.9.3

Recommendations shall be developed and, along with the investigation's results, shall be communicated to the workplace parties. These recommendations shall form the basis of corrective action and shall be included in the management review specified in Clause 5. The investigation results and recommendations should be used for continual improvement of the PHSMS.

#### 4.4.10 External parties

Organizations often engage external providers and suppliers whose personnel interact with those of the organization. The organization shall establish and sustain processes to

- a) make external parties and their personnel aware of the organization's policies and expectations related to protecting the psychological health and safety of the organization's workers; and
- b) address any issues or concerns identified.

**P** The following applies to paramedic service organizations:

If the paramedic service organization is involved in referral to mental health professionals, the organization should ensure such professionals have trauma treatment training and OSI training.

Mental health professionals should have experience with first responders, preferably with paramedics. See Annex G.

**Notes:**

- 1) *Regulated mental health professionals have an ethical responsibility to provide culturally informed care and if that is not possible, to provide an appropriate referral and/or seek out the necessary guidance or training.*
- 2) *The paramedic service organization should consider how collaborations or partnerships may support the implementation of this Standard. External research organizations can provide specialist evaluations and other paramedic and first responder organizations can provide best practices and lessons learned (e.g., stakeholders such as professional bodies, government authorities, medical advisory groups, regulatory bodies, labour groups, etc.).*

## 4.5 Evaluation and corrective action

### 4.5.1 Introduction

The organization shall establish and maintain procedures to monitor, measure, and record psychological health and safety system conformance and the effectiveness of the PHSMS, respecting the confidentiality and privacy of all individuals in accordance with Clause 4.2.5.

The purpose of performance monitoring and measurement is to obtain qualitative and quantitative measurements of

- a) the psychological health and safety of the organization (including promotion, prevention, and intervention efforts); and
- b) organizational conformance to this Standard, including process evaluation.

**Note:** *Evaluation is best planned in advance of implementation so that appropriate data requirements can be identified and subsequently included in the evaluation results.*

### 4.5.2 Monitoring and measurement

**P** The following applies to paramedic service organizations:

**Note:** *Measures for paramedic service organizations could include those areas already assessed and used for the planning process. Making use of these aspects will ensure change from the baseline is assessed and will therefore drive ongoing improvements.*

#### 4.5.2.1

Performance monitoring and measurement shall

- a) determine the extent to which the PHSMS policy, objectives, and targets are being met;
- b) provide data on PHSMS performance and results;
- c) determine whether the day-to-day arrangements for hazard and risk identification, assessment, minimization, and elimination or control are in place and operating effectively; and
- d) provide the basis for decisions about improvements to psychological health and safety of the workplace and the PHSMS.

**Note:** *See Clause 4.3.5 for data sources.*

Both qualitative and quantitative measures appropriate to the needs, size, and nature of the organization shall be developed in consultation with workers and, where applicable, their representatives. Such assessments shall be carried out by competent persons.

#### 4.5.2.2

Monitoring and measurement activities shall be recorded. Monitoring and measurement shall include the requirements of the PHSMS and the results of the following, as applicable:

- a) leadership engagement with the PHSMS;
- b) baseline assessment of psychosocial risk factors;
- c) a baseline assessment of other workplace determinants of psychological health (e.g., environmental, physical, job requirement, staffing levels);
- d) psychological injury and illness statistics;
- e) return-to-work programs;
- f) aggregated data from health risk assessments; and
- g) aggregated analysis of the results of investigations or events.

#### 4.5.3 Internal audits

The organization shall establish and maintain an internal audit program to conduct audits at planned intervals to determine whether the PHSMS

- a) conforms to the requirements of this Standard and to the psychological health and safety system requirements established by the organization; and
- b) is effectively implemented and maintained.

**Note:** *The audit can be scalable to the size, nature, and complexity of the organization. See Annex E in CAN/CSA-Z1003/BNQ 9700-803 for a sample audit tool and CAN/CSA-ISO 19011 for guidelines for managing systems.*

The internal audit program should include the criteria for auditor competency, the audit scope, the frequency of audits, the audit methodology, and reporting.

The audit results, audit conclusions, and any corrective action plans shall be documented and communicated to affected workplace parties, including workers and worker representatives, and those responsible for corrective action.

The organization shall consult with workers and, where applicable, their representatives on auditor selection, the audit process, and the analysis of results.

The management responsible for the activity being audited shall ensure that corrective actions are taken to address any non-conformance with the organization's PHSMS or this Standard identified during the audit.

 The following applies to paramedic service organizations:

[See Annex I for a sample audit tool for the paramedic community and the requirements of this Standard.](#)

#### 4.5.4 Preventive and corrective action

The organization shall establish and maintain preventive and corrective action procedures to

- a) address PHSMS non-conformances and inadequately controlled hazards and their related risks;
- b) identify any newly created hazards resulting from preventive and corrective actions;
- c) expedite action on new or inadequately controlled hazards and risks;
- d) track actions taken to ensure their effective implementation; and
- e) implement initiatives to prevent recurrence of hazards.

The organization shall take into account input from PHSMS performance monitoring and measurement, recommendations from workers and worker representatives, PHSMS audits, and management reviews when determining preventive and corrective actions.

## **5 Management review and continual improvement**

### **5.1 Review process**

The organization shall establish and maintain a process to conduct scheduled management reviews of the PHSMS. The review process should address the degree to which the goals of a psychologically healthy and safe workplace are being achieved.

The review process shall include

- a) a review and analysis of key outcome data (e.g., audit results, evaluation/outcomes data);
- b) an assessment of the level of conformance of the PHSMS to this Standard;
- c) a detailed review of findings that are considered significant; and
- d) organizational and other reporting requirements.

### **5.2 Outcome of the review process**

The outcome of the review process shall include

- a) opportunities for improvement and, where deficiencies/variances are identified, corrective actions to be implemented;
- b) review and update of the organizational policies and procedures specific to or related to the PHSMS;
- c) review and update of objectives, targets, and action plans; and
- d) communication opportunities to enhance understanding and application of results.

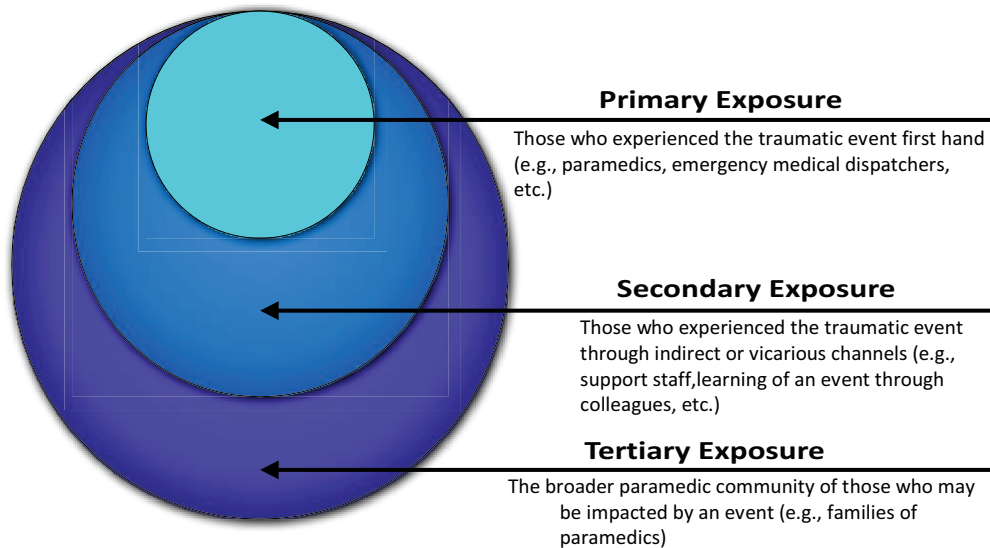
## Annex A (informative)

### Target groups for early intervention programs

**Note:** This Annex is not a mandatory part of this Standard.

Paramedic service organizations should consider the mental health needs of all groups within the paramedic community who might be impacted by critical events. The provision of mental health services should be predicated on the assessment of need and prioritized based on the risk of psychological impact.

Paramedic service organizations should seek guidance from a mental health professional when needed.



**Note:** Depending on the event, those workers classified in each of the above groups can vary.

**Source:** Adapted from the National Organization for Victim Assistance.

## *Annex B (informative)*

# **Workplace factors that could contribute to psychological harm**

### **Notes:**

- 1) *This Annex is not a mandatory part of this Standard.*
- 2) *The workplace factors discussed in this Clause were adapted from GuardingMinds@Work, with the exception of the factor thirteen, “Protection of physical safety”, which was added for the purposes of the CAN/CSA-Z1003/BNQ 9700-803 803 and factors fourteen “Other chronic stressors as identified by workers” and fifteen “Cumulative exposure to critical or stressful events”, which were added to this Standard.*

## **B.1 Workplace psychosocial factors**

While there is a lack of comprehensive mental health prevalence data on paramedics in Canada, it has been reported that members of the paramedic community have higher rates of operational stress injuries (OSIs) than the general population. For many workers, mental health problems are causing significant distress and functional problems in both their personal and professional lives.

The workplace factors listed within Clause 4.3.4.2 can be applied to any workplace environment. When implementing a PHSMS within a paramedic service organization, it is generally understood that there are some areas of higher relevance to paramedic service organizations.

Paramedics serve society and when societal changes occur these changes can have an impact on their work that could impact the physical and psychological health and safety of the worker.

Certain risks to the psychological health and safety of workers is inherent with the nature of the work and cannot be eliminated. The harmful effects of these factors can and should be mitigated wherever possible.

Examples of risks to the psychological health and safety of workers include, but are not limited to, the following:

- a) the aging of the population being served by workers. This is creating an increase in demand, both in terms of the rise in call volume and higher acuity levels;
- b) increasing levels of obesity in the general population at large;
- c) increasing numbers of drug-related calls (e.g., fentanyl overdoses); and
- d) highly regulated industry with many outside influences that continue to evolve and change.

## **B.2 Workplace factors that could contribute to psychological harm**

**Note:** *Portions of this Annex are adapted from CAN/CSA-Z1003-13/BNQ 9700-803/2013, Clause A.4.*

The fifteen workplace factors listed in Figure 2 are organizational or systemic in nature and therefore within the influence of the workplace. These factors are described more fully in Items 1 to 15.

Addressing them effectively has the potential to positively impact worker mental health, psychological safety, and participation. This in turn can improve productivity and bottom line results.

**Note:** *While psychological health and psychological safety are deserving of equal protection, it is important to note that, from a strategic perspective, ensuring safety (in the sense of preventing psychological harm) is a prerequisite to the promotion of health.*

The statements for each factor are provided to help users think about the current state of their own workplace. The more strongly users agree with the statements, the more likely users have a psychologically safe workplace:

The following outlines some of the types of general workplace and unique or prevalent hazards encountered by workers. These workplace factors are not an exhaustive list and are given as examples to broaden the understanding of some of the unique challenges in the paramedic community. Each paramedic service organization will have their own set of unique factors that can impact workers and should be evaluated. For general information on workplace psychosocial factors that impact all workplaces, see Clause 4.3.4.2.

### 1. Psychological and social support

Psychological and social support comprises all supportive social interactions available at work, either with co-workers or supervisors. It refers to the degree of social and emotional integration and trust among co-workers and supervisors. It refers also to the level of help and assistance provided by others when one is performing tasks. Equally important are the workers' perceptions and awareness of organizational support. When workers perceive organizational support, it means they believe their organization values their contributions, is committed to ensuring their psychological well-being, and provides meaningful support if this well-being is compromised.

An organization with good psychological and social support would be able to state that

- the organization offers services or benefits that address worker psychological and mental health;
- workers feel part of a community and that the people they are working with are helpful in fulfilling the job requirements;
- the organization has a process in place to intervene if an employee looks distressed while at work;
- workers feel supported by the organization when they are dealing with personal or family issues;
- the organization supports workers who are returning to work after time off due to a mental health condition; and
- people in the organization have a good understanding of the importance of worker mental health.

A paramedic service organization with good psychological and social support would be able to state that

- the paramedic service organization offers access to appropriate and effective formal supports, including effective EFAP resources, peer support teams, critical incident services (CIS);
- the paramedic service organization offers access to mental health professionals who are competent in first responder interaction and peer support teams;
- there is a presence of informal supports such as co-workers as a support system, family, friends, and community resources;
- effective RTW/SAW programs are worker-centered;
- all staff are well versed in, and comfortable discussing, mental health problems;
- the organization and its members do not tolerate stigmatizing behaviours; and
- the psychological wellness of the leadership.

### 2. Organizational culture

Organizational culture is a mix of norms, values, beliefs, meanings, and expectations that group members hold in common and that they use as behavioural and problem-solving cues. Organizational culture could enhance the psychological health and safety of the workplace and the workforce when it is characterized by trust, honesty, respect, civility, and fairness or when it values, for example, psychological and social support, recognition, and reward.

An organization with good organizational culture would be able to state that

- all people in the workplace are held accountable for their actions;
- people at work show sincere respect for others' ideas, values, and beliefs;
- difficult situations at work are addressed effectively;
- workers feel that they are part of a community at work; and



- workers and management trust one another.

A paramedic service organization with good organizational culture would be able to state that

- the primary focus, or key drivers of decision making, include consideration of humanistic factors in the paramedic community;
- the psychological needs and wellness of the front-line worker are key considerations in organizational decision making;
- there is a high degree of trust between the front-line workers and management (lack of an “us vs them” culture); and
- there is a high degree of honesty, and fairness exhibited within the paramedic service organization.

### 3. Clear leadership and expectations

Clear leadership and expectations is present in an environment in which leadership is effective and provides sufficient support that helps workers know what they need to do, explains how their work contributes to the organization, and discusses the nature and expected outcomes of impending changes. There are many types of leadership, each of which impacts psychological safety and health in different ways. The most widely accepted categorizations of leadership are instrumental, transactional, and transformational. Of these, transformational leadership is considered the most powerful. Instrumental leadership focuses primarily on producing outcomes, with little attention paid to the “big picture”, the psychosocial dynamics within the organization, and unfortunately, the individual workers. Transformational leaders are seen as change agents who motivate their followers to do more than what is expected. They are concerned with long-term objectives and transmit a sense of mission, vision, and purpose. They have charisma, give individual consideration to their workers, stimulate intellectual capabilities in others, and inspire workers.

An organization with clear leadership and explicit expectations would be able to state that

- in their jobs, workers know what they are expected to do;
- leadership in the workplace is effective;
- workers are informed about important changes at work in a timely manner;
- supervisors provide helpful feedback to workers on their expected and actual performance; and
- the organization provides clear, effective communication.

A paramedic service organization with good leadership and explicit expectations would be able to state that

- there is a clear understanding of the expectations of management by those at the front line;
- there is consistency in the adherence to policy throughout the organization; and
- messaging from management and leadership is consistent.

### 4. Civility and respect

Civility and respect is present in a work environment where workers are respectful and considerate in their interactions with one another, as well as with customers, clients, and the public. Civility and respect are based on showing esteem, care, and consideration for others, and acknowledging their dignity.

An organization with good civility and respect would be able to state that

- people treat each other with respect and consideration in the workplace;
- the organization effectively handles conflicts between stakeholders (workers, customers, clients, public, suppliers, etc.);
- workers from all backgrounds are treated fairly in our workplace; and
- the organization has effective ways of addressing inappropriate behaviour by customers or clients.

A paramedic service organization with good civility and respect would be able to state that

- there is a spirit of camaraderie (as opposed to animosity) that defines the environment of the paramedic service organization;
- there is a high degree of respect exhibited in the interaction between the unionized staff, union representative, and management staff (as opposed to confrontational or hostile relationships); and
- respect is exhibited during interaction between the worker and other stakeholders.

## 5. Psychological demands

Psychological demands of any given job are documented and assessed in conjunction with the physical demands of the job. Psychological demands of the job will allow organizations to determine whether any given activity of the job might be a hazard to the worker's health and well-being. When hazards are identified, organizations consider ways of minimizing risks associated with identified job hazards through work redesign, analysis of work systems, risk assessment, etc. The assessment of psychological demands should include assessment of time stressors (including time constraints, quotas, deadlines, machine pacing, etc.); breaks and rest periods; incentive systems (production bonuses, piece work, etc.); job monotony and the repetitive nature of some work; and hours of work (overtime requirements, 12 h shifts, shift work, etc.).

An organization with a good psychological demands assessment process for its workers would be able to state that

- the organization considers existing work systems and allows for work redesign;
- the organization assesses worker demand and job control issues such as physical and psychological job demands;
- the organization assesses the level of job control and autonomy afforded to its workers;
- the organization monitors the management system to address behaviours that impact workers and the workplace;
- the organization values worker input particularly during periods of change and the execution of work;
- the organization monitors the level of emphasis on production issues;
- the organization reviews its management accountability system that deals with performance issues and how workers can report errors; and,
- the organization emphasizes recruitment, training, and promotion practices that aim for the highest level of interpersonal competencies at work.

A paramedic service organization with a good psychological demands assessment process for its workers would be able to state that

- there is an understanding of the chronic and acute stress of the inherent physical, mental and moral job demands facing workers (see workplace factor 14);
- workers have a good understanding of the psychological job demands at the beginning and throughout their career;
- there is a degree of certainty and predictability of the day-to-day job demands;
- there is recognition and support for maintaining healthy work relationships with co-workers, in particular partners, while under high stress situations and low control situations;
- the risk of, and potential impact of, operational or clinical errors are understood;
- the impact of public scrutiny on workers is understood and recognized (e.g., cell phones, social media);
- supervisors have an appropriate span of control to ensure they are able to provide support to their staff and detect when staff are experiencing potential mental health problems; and
- the investigation process for health and safety concerns is effective and easy for workers to report.

## 6. Growth and development

Growth and development is present in a work environment where workers receive encouragement and support in the development of their interpersonal, emotional, and job skills. Such workplaces provide a range of internal and external opportunities for workers to build their repertoire of competencies, which will not only help with their current jobs, but will also prepare them for possible future positions.

An organization with good growth and development would be able to state that

- workers receive feedback at work that helps them grow and develop;
- supervisors are open to worker ideas for taking on new opportunities and challenges;
- workers have opportunities to advance within their organization;
- the organization values workers' ongoing growth and development; and
- workers have the opportunity to develop their "people skills" at work.

A paramedic service organization with good growth and development would be able to state that

- a diversity of options for growth (i.e., management, education, public relations, planning, quality assurance, etc.) are present in the paramedic service organization;
- promotion is based on competencies that include interpersonal skills, psychological skills, and emotional intelligence;
- there is support for lifelong learning;
- the organization offers fair access to tuition assistance or scholarships;
- flexible scheduling opportunities are made available to complete training and education programs; and
- there are opportunities to explore different career paths or interests.

## 7. Recognition and reward

Recognition and reward is present in a work environment where there is appropriate acknowledgement and appreciation of workers' efforts in a fair and timely manner. This includes appropriate and regular acknowledgements such as worker or team celebrations, recognition of good performance and years served, and/milestones reached.

An organization with a good recognition and reward program would be able to state that

- immediate supervision demonstrates appreciation of workers' contributions;
- workers are paid fairly for the work they do;
- the organization appreciates efforts made by workers;
- the organization celebrates shared accomplishments; and
- the organization values workers' commitment and passion for their work.

A paramedic service organization with a good recognition and reward program would be able to state that

- formal recognition and reward programs [e.g., save pins for each return of spontaneous circulation (ROSC) that survives to hospital discharge, 'thank you' notes from patients or family, 'good news' announcements at roll call] are consistently administered;
- recognition is meaningful to those who receive it; and
- recognition is delivered in a timely manner.

## 8. Involvement and influence

Involvement and influence is present in a work environment where workers are included in discussions about how their work is done and how important decisions are made. Opportunities for involvement can relate to a worker's specific job, the activities of a team or department, or issues involving the organization as a whole.

An organization with good involvement and influence would be able to state that

- workers are able to talk to their immediate supervisors about how their work is done;
- workers have some control over how they organize their work;
- worker opinions and suggestions are considered with respect to work;
- workers are informed of important changes that can impact how their work is done; and
- the organization encourages input from all workers on important decisions related to their work.

A paramedic service organization with good involvement and influence would be able to state that

- there is ample opportunity for engagement (i.e., ability to make positive changes in the service through involvement in committees, research, and community outreach);
- the front line staff are engaged in the strategic planning and forecasting for the paramedic service organization;
- the front line staff feel listened to by decision makers; and
- involvement and influence in decision making is not restricted to a select few stakeholders within the organization.

## 9. Workload management

Workload management is present in a work environment where assigned tasks and responsibilities can be accomplished successfully within the time available. This is the risk factor that many working Canadians describe as being the biggest workplace stressor (i.e., having too much to do and not enough time to do it). It has been demonstrated that it is not just the amount of work that makes a difference but also the extent to which workers have the resources (time, equipment, support) to do the work well.

An organization with good workload management would be able to state that

- the amount of work workers are expected to do is reasonable for their positions;
- workers have the equipment and resources needed to do their jobs well;
- workers can talk to their supervisors about the amount of work they have to do;
- workers' work is free from unnecessary interruptions and disruptions; and
- workers have an appropriate level of control over prioritizing tasks and responsibilities when facing multiple demands.

A paramedic service organization with good workload management would be able to state that

- employees know what they need to do, how their work contributes to the organization, and whether there are pending changes;
- workers have an appropriate balance of call volume vs. downtime;
- workers have an appropriate balance of high and low call acuity (burn out vs. boredom and loss of confidence);
- call duration is factored in to the measurement of workload; and
- adequate planning is carried out to ensure staffing levels offset surges in call volume.

## 10. Engagement

Engagement is present in a work environment where workers enjoy and feel connected to their work and where they feel motivated to do their job well. Worker engagement can be physical, emotional, or cognitive. Physical engagement is based on the amount of exertion a worker puts into his or her job. Physically engaged workers view work as a source of energy. Emotionally engaged workers have a positive job outlook and are passionate about their work. Cognitively engaged workers devote more attention to their work and are absorbed in their job. Whatever the source, engaged workers feel connected to their work because they can relate to, and are committed to, the overall success and mission of their company. Engagement should be seen as a result of policies, practices, and procedures

for the protection of worker psychological health and safety. Engagement is similar to, but is not to be mistaken for, job satisfaction, job involvement, organizational commitment, psychological empowerment, and intrinsic motivation.

An organization with good engagement would be able to state that

- workers enjoy their work;
- workers are willing to give extra effort at work if needed;
- workers describe work as an important part of who they are;
- workers are committed to the success of the organization; and
- workers are proud of the work they do.

A paramedic service organization with good engagement would be able to state that

- there is opportunity for meaningful engagement in the workplace (i.e., ability to make positive changes in the service through involvement in committees, research, and community outreach);
- workers show pride in the paramedic service organization;
- there is acknowledgement of, and action on, the concerns of all workers within the paramedic service organization; and
- there is a sense of belonging by individuals or groups of individuals within the paramedic service organization exists.

### 11. Work/life balance

Work/life balance is present in a work environment where there is acceptance of the need for a sense of harmony between the demands of personal life, family, and work. This factor reflects the fact that everyone has multiple roles: as workers, parents, partners, etc. This complexity of roles is enriching and allows fulfillment of individual strengths and responsibilities, but conflicting responsibilities can lead to role conflict or overload.

An organization with good work/life balance would be able to state that

- the organization encourages workers to take their entitled breaks (e.g., lunchtime, sick time, vacation time, earned days off, parental leave);
- workers are able to reasonably meet the demands of personal life and work;
- the organization promotes life-work harmony;
- workers can talk to their supervisors when they are having trouble maintaining harmony between their life and work; and
- workers have energy left at the end of most workdays for their personal life.

A paramedic service organization with good work/life balance would be able to state that

- the effects of shift work and fatigue on the workers is recognized;
- worker fatigue due to shift patterns and durations is monitored and addressed;
- the impact of personal stressors (financial, relationships, health) is acknowledged; and
- there is recognition of the impact of the potential effects of the job on family and social relationships.

### 12. Psychological protection

Psychological protection is present in a work environment where workers' psychological safety is ensured. Workplace psychological safety is demonstrated when workers feel able to put themselves on the line, ask questions, seek feedback, report mistakes and problems, or propose a new idea without fearing negative consequences to themselves, their job, or their career. A psychologically safe and healthy organization actively promotes emotional well-being among workers while taking all reasonable steps to minimize threats to worker mental health.

An organization with good psychological protection would be able to state that

- the organization is committed to minimizing unnecessary stress at work;
- immediate supervisors care about workers' emotional well-being;
- the organization makes efforts to prevent harm to workers from harassment, bullying, discrimination, violence, or stigma;
- workers would describe the workplace as being psychologically healthy; and
- the organization deals effectively with situations that can threaten or harm workers (e.g., harassment, bullying, discrimination, violence, stigma).

A paramedic service organization with good psychological protection would be able to state that

- opportunities for training and resources that address non-violent conflict resolution are provided;
- personal coping strategies are developed and encouraged to help manage the day-to-day psychological job demands;
- workers possess the skills and knowledge to be able to support and cope with potential mental health problems of work partners and colleagues;
- skills and competencies are maintained and updated or refreshed on an ongoing basis;
- trust exists in the relationships between partners;
- social connections within the paramedic service organization are supported;
- issues surrounding working alone and working in isolation with minimal ability for social interaction in the workplace are recognized and mitigated wherever possible;
- mental wellness of all workers is supported through education and availability of effective treatment options; and
- opportunities for training in the skills and knowledge of self-defense and self-protection strategies are provided.

### 13. Protection of physical safety

Protection of physical safety is present when a worker's psychological as well as physical safety is protected from hazards and risks related to the worker's physical environment.

An organization that protects physical safety would be able to state that

- the organization cares about how the physical work environment impacts mental health;
- workers feel safe (not concerned or anxious) about the physical work environment;
- the way work is scheduled allows for reasonable rest periods;
- all health and safety concerns are taken seriously;
- workers asked to do work that they believe is unsafe have no hesitation in refusing to do it;
- workers get sufficient training to perform their work safely; and
- the organization assesses the psychological demands of the jobs and the job environment to determine if it presents a hazard to workers' health and safety.

A paramedic service organization that protects physical safety would be able to state that

- consideration is given to exposure to environmental and extreme weather conditions (e.g., ensure proper clothing and equipment);
- traffic hazards, other scene risks, and availability of backup (e.g., other crews, supervisors) are considered when responding to routine and large scale calls, are monitored and measured, and controls are put in place to assist in mitigating these risks; and
- communications officers are able to detect and respond accordingly when a crew is in potential danger (emergency panic button activation).

#### 14. Other chronic stressors as identified by workers

Chronic stressors as identified by workers as they relate to the paramedic service organization include, but are not limited to,

- a base-paging or notification system which elicits a startle response by using loud or noxious stimuli when activated;
- risk of a worker having to respond to calls for close family and friends;
- serious injury or death of an emergency team member in the line of duty;
- serious injury or death of a civilian resulting from service operations;
- cases charged with profound emotion such as the death of an infant;
- cases that attract unusual attention from the news media;
- a loss of life after a prolonged rescue effort;
- serious physical or psychological threat to the rescuers;
- incidents that surpass the normal coping mechanisms or personnel;
- exposure to pathogens;
- threats of both verbal and physical violence;
- injury and death due to vehicle related accidents; and
- dealing with acutely ill or seriously injured people.

A paramedic service organization that addresses other chronic stressors as identified by workers should be able to state that

- there is a strategy in place to recognize, assess, monitor, and mitigate chronic stressors as identified by the workers;
- the organization strives to maintain respected relationships with the community at large;
- there is a process in place to mitigate risks of workers responding to calls for family or close friends of the worker; and
- the base-paging or call notification system utilized in the workplace is designed to minimize the startle response.

#### 15. Cumulative exposure to critical or stressful events

The following list includes, but is not limited to, other potential cumulative exposure elements that could be present within a paramedic service organization:

- exposure to events that can elicit feelings of helplessness, hopelessness, or horror;
- frequency and severity of exposure to traumatic events;
- vicarious (secondary) trauma from the impact of critical events of other colleagues;
- compassion fatigue and burnout;
- stress related illnesses and behaviours, if left untreated or not addressed due to stigma, lack of tools, and/or lack of knowledge of how to deal with these issues;
- inability for closure;
- grief; and
- exposure to events which can incur a moral conflict.

A paramedic service organization that mitigates cumulative exposure to critical or stressful events would be able to state that

- individual exposure for frequency and severity of exposure to critical or stressful events is monitored, recognized, assessed, and addressed;
- opportunities for training in recognizing and managing cumulative exposure to critical or stressful events are provided;
- system strategies or processes to address cumulative exposure to critical or stressful events are in place and are trusted by the workers; and

- access to training, resources and tools surrounding vicarious (secondary) trauma, compassion fatigue, burnout, grief, and moral conflicts is provided.



## Annex C (informative)

# Confidentiality

**Note:** This Annex is not a mandatory part of this Standard.

### C.1 Informed consent

Paramedic service organizations may encourage workers to utilize mental health services; however, workers should provide informed consent to participate in those services and their confidentiality needs to be protected. Mental health services may include those delivered by trained peer support services or a regulated mental health professional.

Informed consent includes all of the following:

- terms of participation;
- confidentiality and its limitations;
- description of the services offered; and
- the workers(s) right to decline services.

**Note:** Informed consent should not supersede standard emergency response measures (e.g., initiating a 9-1-1 call) when there is imminent risk of harm to self or others.

### C.2 Confidentiality

Confidentiality is the protection of information related to workers' mental health or mental health-care. The purpose of confidentiality is to protect the integrity of mental health services and promote workers' willingness to access those services. Confidential information is not to be shared unless there is imminent risk of harm to self or others.

Two categories of confidential information relevant to the paramedic service organizations are as follows:

#### 1. Mental healthcare service provider

This section pertains to mental healthcare offered to or received by workers from a mental health service provider, which may include, but is not limited to, a mental health professional, peer support service provider, and employee assistance program (EAP) provider. The following apply irrespective of whether the services are delivered internally within the paramedic service organization (e.g., staff mental health professional or internal peer support team) or externally (e.g., consulting mental health professional or external peer support team):

- Confidentiality is the protection of information gleaned through one's role in providing mental healthcare. The term "confidentiality" herein applies to all information that becomes known directly or indirectly through the service provider's role in delivering mental healthcare.
 

**Note:** This includes information learned through any source, including but not limited to notes of mental health sessions, phone conversations, voicemails, text messages, emails, etc.
- Confidentiality is maintained at all times, both within and outside the service provider's role in delivering mental healthcare and regardless of the amount of time that has passed. Confidentiality is to be maintained even if the service provider's role has ended and also beyond the death of a worker.
- The collection, storage, maintenance, disclosure, and destruction of confidential information meets or exceeds the applicable territorial, provincial, and federal confidentiality and privacy legislation.

The following exceptions to confidentiality apply:

- when written permission from the worker is provided;

- imminent risk of harm to self or others; or
- requirements of applicable territorial, provincial, and federal legislation.

**Note:** *This does not include internal investigations conducted by the paramedic service organization or other bodies overseeing the practice of paramedicine. In those situations, written permission is required from the worker before confidential information can be disclosed.*

## **2. Employer**

This section pertains to any personal health information that a paramedic service organization might have in their possession, which contains information about the mental health or mental healthcare of their workers. Access to or disclosure of this information is restricted except with the written permission of the worker or as required by the applicable territorial, provincial, and federal legislation. The information is not to be used for disciplinary measures.

## *Annex D (informative)*

# **Implementation case study example**

**Note:** This Annex is not a mandatory part of this Standard.

### **D.1 An organization supports its workers**

#### **Background**

A Canadian paramedic service organization serves 1.4 million residents across a diverse geographic area. There are 700 full-time, 200 part-time or casual workers including paramedics, support staff, fleet staff, communications staff, and management in multiple locations throughout the region. Seventy-five percent (75%) of the workforce belongs to one of five unions.

The organization decided to improve the psychological health and safety of its workplace. It made the decision for reasons that include an attempt to decrease costs associated with mental health issues; in response to surveys that indicated staff were experiencing considerable stress; and to enhance its reputation as a great place to work. As the organizational representative noted, “Not only does it make business ‘cents’, it’s the right thing to do”.

The organization’s ultimate goal was to implement CAN/CSA-Z1003/BNQ 9700-803 across the entire organization. A recent increase in absences due to mental health problems as well as pressure from paramedic associations have led to several recommendations intended to improve employee psychological safety.

#### **Planning**

The organization incorporated psychological health and safety into decision-making and key organizational policies in many ways. Primary among them was the decision to focus on the continuum of psychological health to incorporate positive functioning as well as mental health difficulties. This was reflected in the drafting or revision of relevant policies, such as the Healthy Workplace Policy, Harassment and Discrimination Policy, and new Staff Code of Conduct. In addition, several new policies were created, including a confidentiality policy, a return-to-work or stay-at-work policy, and a stigma reduction policy.

Early in the planning process, the organization conducted a psychosocial risk survey and there was a perceived disconnect between management and front-line staff. The outcome of the survey indicated that front-line staff felt undervalued and under-appreciated, and an overall lack of support for their mental health. After some discussions between members, union representatives and senior leaders, a joint union-management task force was created to develop a psychological health and safety strategy to implement actions and monitor progress, acknowledging that the organizational culture is one of the risk factors contributing to stress injuries. Clear communication was maintained with all stakeholders through all phases of the implementation.

The task force reviewed these results to identify which psychosocial workplace factors were of most relevance to the staff. This would serve not only to identify specific issues to focus on, but also to recognize protective factors, both of which informed program development. As an example, there was significant concern about chronic/cumulative exposure to critical events.

Key indicators of relevance to psychological health and safety were identified to help with evaluation, such as benefits utilization, drug usage, professional services accessed, frequency of critical events, and

EAP visits. The task force also gathered leading indicator information, including orientation results, training participation rates and utilization of the intranet site.

### Actions

On the basis of its analysis, the organization took the following actions with regard to psychological health and safety:

- Created a dedicated intranet site for staff with information on relevant psychological health and safety policies, programs, and resources. New staff would receive an introduction to this during orientation and are expected to complete an online module to enhance knowledge transfer.
- Developed an integrated psychological health promotion program for staff, including training in resiliency, team building, and psychological safety skills. This was complemented with access to online self-care modules on topics such as depression, anxiety, trauma-related disorders, and substance misuse.
- Prioritized leadership development, as this influences the success of all other actions. To this end, leader competencies were reviewed and training was provided in areas including transformational leadership, effective communications, and how to support staff. These skills were incorporated in regular performance reviews for managers.
- Revised the critical incident stress management program. Whereas the prior focus had solely been on a team debriefing following a serious incident, the program was expanded to improve the incident reporting process and include a range of individual or group options in response to such events.
- Implemented family education nights for family members of all staff (including new employees) to provide mental health awareness and education about self-care practices, resiliency, recognizing signs of stress, available resources, suicide prevention, and interventions.
- Created a critical event preparedness plan for individuals and the organization to ensure that psychological support is considered.
- Initiated a peer support program.

In addition, the program was linked to other services and areas in the region, such as staff development and disability management.

### Results

Despite some initial struggles, the organization made significant progress in implementing this Standard. Members of the task force were invited to discuss their implementation process, including challenges and opportunities, at various staff forums, including a presentation to the senior management. This contributed to assessing the performance and taking appropriate actions to correct or improve outcomes in the future. The recommended process to implement the Standard has been incorporated into the human resources business plan and the goal is to ensure that psychological health and safety is integrated into the overall health and safety management system.

In the following year, a gap analysis was done. It identified some missing elements in order to fully meet the Standard. The Task Force was mandated to continue to work and address the gaps. This included addressing the following:

- flexible and individualized return-to-work program;
- data on existing exposure to traumatic material;
- access to a list of mental health professionals providing evidence-informed treatment approaches with a minimum level of training on trauma to all staff;
- formal mutual aid support agreements with other first responder agencies;
- post-vention training and post-vention program;
- opportunities for training to retiring and retired staff and family; and

- training for supervisors and managers on investigation of psychological health and safety incidents.

An organizational representative provided the following observation about the implementation journey: “It has been an exciting learning opportunity for the organization, not only that there is the Standard and what it means, but there is the provision of tools and resources to implement this Standard; recognizing it is a continuous process and not an end point.”

**Source:** *This fictional case study has been adapted with the permission of the Mental Health Commission of Canada (MHCC) from the first responder case study found within the Mental Health Commission of Canada’s (MHCC) report Case Study Research Project Findings (2017). Ottawa, ON: Mental Health Commission of Canada. This report highlights findings of MHCC’s three year implementation study to gather promising practices of implementing CAN/CSA-Z1003/BNQ 9700-803. While this adaptation has been authorized, MHCC is not responsible for its adaptation, the manner in which the data is presented, nor for any interpretations thereof. All rights in the report are reserved.*

## *Annex E (informative)*

### **Peer support programs**

**Note:** This Annex is not a mandatory part of this Standard.

#### **E.1 General**

The Mental Health Commission of Canada's *Guidelines for the Practice and Training of Peer Support* indicate that peer support is a means of connecting with another person who has lived with similar problems, or is perhaps still doing so. It can be a vital link for someone struggling with their own situation. Peer support can be an effective prevention strategy, and can moderate the effects of life-challenging events and provide a sense of empowerment. Research also indicates that peer support can help a person gain control over their symptoms, reduce hospitalization, offer social support, and improve quality of life. The information, empowerment, and hope that come from someone who has been in their shoes can help a person better navigate the sometimes complicated maze of treatments and other forms of assistance.

#### **E.2 Implementing peer support programs**

A peer support program developed by paramedic service organizations should develop guidelines and procedures that meet best practices standards and tailor the program to meet the individual organizational needs. The program should have auditable protocols that are developed in advance of implementation.

General considerations when implementing a peer support program are as follows:

- a) ensure that industry best practices are followed;
- b) select programs which meet the unique needs of paramedics;
- c) implement programs in a proactive way as part of regular procedures;
- d) provide programs that are evidence-informed, facilitate support, build readiness, increase resilience, and reduce stigma;
- e) remain current and transparent in the development, application, and assessment of programs;
- f) provide ongoing training, oversight, consultation, and support for personnel involved in implementing programs; and
- g) obtain feedback from participants on their experience with programs and expectations and preferences for receiving support programs.

#### **E.3 Confidentiality**

Due to the sensitive nature of offering peer support in the workplace and stigma related to mental health problems that can be pervasive in some organizations, it is critical that care be taken to develop peer support program confidentiality standards, policies, and procedures. The success of the peer support program relies on confidentiality. Workers must feel confident and trust that confidentiality is a foundational principle, and that there are consequences when personal health information is disclosed. For more information on confidentiality, see Annex C.

#### **E.4 Resources**

For further information on how to set up a peer support program, the following resources might be useful:

Mood Disorders Society of Canada. *Peer & Trauma Support Systems*:  
[mdsc.ca/peer-and-trauma-support-systems/](https://mdsc.ca/peer-and-trauma-support-systems/)

Simon Fraser University. *First Responders Trauma Prevention and Recovery*:  
[sfu.ca/continuing-studies/programs-and-courses/area-of-study/workplace-health-and-wellness/first-responders-trauma-management.html](http://sfu.ca/continuing-studies/programs-and-courses/area-of-study/workplace-health-and-wellness/first-responders-trauma-management.html)

TEMA.CA. *The First Responder Trauma Prevention and Peer Support Training Program*:  
[tema.ca/first-responder](http://tema.ca/first-responder)

To learn more about best practice guidelines, the following resources might be useful:

Mental Health Commission of Canada. *Guidelines for the Practice and Training of Peer Support*:  
[mentalhealthcommission.ca/sites/default/files/peer\\_support\\_guidelines.pdf.pdf](http://mentalhealthcommission.ca/sites/default/files/peer_support_guidelines.pdf.pdf)

Peer Support Accreditation and Certification (Canada):  
[psac-canada.com/](http://psac-canada.com/)

Tunnecliffe, M. (2007) Best practice in peer support. *Emergency Support Network*. Retrieved 2016, October 20, from [http://www.emergencysupport.com.au/articles/PeerSupport\\_BESTPRACTICE.pdf](http://www.emergencysupport.com.au/articles/PeerSupport_BESTPRACTICE.pdf)

## *Annex F (informative)*

# **Stay-at-work and return-to-work programs**

**Note:** This Annex is not a mandatory part of this Standard.

### **F.1 General**

A stay-at-work and return-to-work program is an important aspect of being prepared to support a worker to recover and successfully return to work. As part of the planning process, the organization shall review its workplace policies and procedures regarding stay at work and return to work. The organization should develop, implement, and maintain stay-at-work and return-to-work programs as part of the PHSMS, in conjunction with the applicable legislation within each province/territory. Employers should keep workers informed about these programs and processes throughout their career (e.g., orientation, team meetings, and union meetings).

### **F.2 Stay-at-work (SAW) program**

#### **F.2.1**

Following the identification of a critical event, personal crisis, or any personal limitation, the organization should provide psychological support and/or workplace accommodation for cognitive/psychological limitations, such as

- a) contact and engagement;
- b) safety and comfort;
- c) stabilization;
- d) information gathering: current needs, concerns, limitations;
- e) practical assistance;
- f) connection with social supports;
- g) information on coping;
- h) linkage with collaborative services; and
- i) medical assessment for cognitive/psychological limitations as applicable.

#### **F.2.2**

With these factors in mind, the organization should consider a formal SAW accommodation plan. The workplace should consider

- a) employee needs and limitations;
- b) ability to accommodate employee in their current job (modified duties and/or modified hours);
- c) availability of other work if unable to perform regular duties;
- d) available resources;
- e) follow-up (considering the physical and psychological health of the employee, coping strategies, need for further referral, etc.); and
- f) steps in RTW plan development (see Clause [F.3](#)).

### **F.3 Return-to-work (RTW) program**

In developing RTW programs, the organization should consider the respect, dignity, individualization, and inclusion of the worker. The workplace needs to have a strong commitment to health and safety,



which is demonstrated by the behaviours of the workplace parties. At a minimum, the following steps should be incorporated within the organization's return-to-work program:

- a) The workplace makes an offer of modified work/accommodation so the worker can return early and safely to work activities suitable to their abilities.
- b) RTW planner ensures that the plan supports the returning worker without disadvantaging co-workers and supervisors. As part of this process, workplace and job demands analysis are provided to the treating practitioner, as appropriate, with employee consent. Refer to the *Supporting Employee Success tool*:  
<https://www.workplacestrategiesformentalhealth.com/managing-workplace-issues/supporting-employee-success-a-tool-to-plan-accommodations>
- c) The RTW planner is assigned and responsible for coordinating case management meeting(s) that could include individual roles such as occupational health professional, employee, worker representative, direct supervisor, or manager, etc., as applicable and as required. The employee should always be included unless contraindicated (as assessed by the regulated healthcare professional).
- d) Supervisors are trained to understand their role in being positive and empathetic in early contact with workers, arranging and implementing of the RTW plan, and importance of regular follow-up and problem solving.
- e) A worker centered return-to-work plan is developed that is
  - i) individualized according to restrictions/limitations;
  - ii) flexible;
  - iii) modifiable including ability to be graduated;
  - iv) supported by all parties involved in the RTW plan; and
  - v) developed with involvement of the employee.
- f) The plan is implemented.
- g) There are regular follow-up meetings to check progress (to ensure that plans put into place are meeting the needs of the individual and modify accordingly).
- h) There is a return-to-practice assessment (clinical evaluation, making up CME sessions, certification renewal/initiation).

Despite the best efforts of all involved parties, the employees are sometimes unable to return to work within a reasonable period of time in a reasonable capacity, due to the nature of the injury, illness, or medical condition. At other times, repeated return-to-work attempts are unsuccessful. In these cases, there should be consultation with the insurance provider (e.g., benefits provider and workers compensation bureau) and human resources department regarding future options.

**Note:** *In Canada, regulations can differ across jurisdictions; it is the user's responsibility to determine how applicable legislative requirements relate to this Standard.*

## F.4 Resources

For further information on developing a stay-at-work and return-to-work program, the following resources might be useful:

Great-West Life: Centre for Mental Health in the Workplace. Workplace Strategies for Mental Health:  
<https://www.workplacestrategiesformentalhealth.com>

Institute for Work & Health. 2007 (rev. 2014) *Seven "Principles" for Successful Return to Work*:  
[https://www.iwh.on.ca/system/files/documents/seven\\_principles\\_rtw\\_2014\\_0.pdf](https://www.iwh.on.ca/system/files/documents/seven_principles_rtw_2014_0.pdf)

Institute for Work & Health. 2009. *Red Flags Green Flags: A Guide to Identifying and Solving Return to Work Problems*:

[https://www.iwh.on.ca/system/files/documents/rtw\\_problems\\_guide\\_2009\\_0.pdf](https://www.iwh.on.ca/system/files/documents/rtw_problems_guide_2009_0.pdf)

Institute for Work & Health. 2009. *Red Flags Green Flags: Summary Card*. Institute for Work and Health:  
[https://www.iwh.on.ca/system/files/documents/rtw\\_problems\\_cards\\_2009\\_1.pdf](https://www.iwh.on.ca/system/files/documents/rtw_problems_cards_2009_1.pdf)

National Institute of Disability Management and Research:

[www.nidmar.ca](http://www.nidmar.ca)

Pacific Coast University for Workplace Health Sciences:

[www.pcu-whs.ca](http://www.pcu-whs.ca)

## *Annex G (informative)*

# **Regulated mental health professional**

**Note:** *This Annex is not a mandatory part of this Standard.*

### **G.1 Regulated mental health professional**

Regulated or licensed mental health professionals are governed under a legislative framework which establishes health regulatory colleges that regulate in the public interest. Health regulatory colleges are responsible for ensuring that regulated mental health professionals provide mental health services in a safe, professional, and ethical manner. Not all mental health professionals are regulated. Employers and workers should investigate prior to engaging in services, especially if a regulated professional is required to meet regulatory obligations. If an organization is using a third-party health service provider (e.g., insurance company) for this purpose, the employer and worker should investigate if quality assurance and oversight are in place to ensure that quality professional services are being provided.

A resource for further information in this area is

Ontario Psychological Association

<http://www.psych.on.ca/About-Psychology/Professional-Comparison-Chart>

## Annex H (informative)

### Post-traumatic stress disorder

**Note:** This Annex is not a mandatory part of this Standard.

**Note:** This Annex is based on information provided by the U.S. Department of Veterans Affairs that puts the DSM-5 criteria into more layman's terms: [https://www.ptsd.va.gov/professional/PTSD-overview/dsm5\\_criteria\\_ptsd.asp](https://www.ptsd.va.gov/professional/PTSD-overview/dsm5_criteria_ptsd.asp).

#### H.1

Post-traumatic stress disorder (PTSD) is a DSM-5 diagnosis characterized by the development of a specified number of symptoms, as assessed by a regulated health professional authorized to communicate a diagnosis (e.g., psychiatrist, psychologist), which include four clusters or types of symptoms occurring after a person was exposed to death, threatened death, actual or threatened serious injury, or actual or threatened sexual violence in one or more of the following ways:

- a) direct exposure;
- b) witnessing the trauma;
- c) learning that a relative or close friend was exposed to a trauma; and
- d) indirect exposure to aversive details of the trauma, such as in the course of professional duties.

**Note:** DSM-5 refers to the Diagnostic and Statistical Manual of Mental Disorders: [psychiatry.org/psychiatrists/practice/dsm](http://psychiatry.org/psychiatrists/practice/dsm)

#### H.2

The four PTSD symptom clusters include

- a) at least one re-experiencing symptom (i.e., distressing experiences of reliving the traumatic event via unwanted thoughts or memories, nightmares, flashbacks of the trauma; and/or experiencing emotional or physical reactivity after exposure to traumatic reminders);
- b) at least one avoidance symptom (i.e., active and frequent avoidance of thoughts, feelings, and/or situations that remind them of the trauma);
- c) at least two symptoms related to negative thoughts or feelings that began or worsened after the trauma (e.g., unable to recall key features of the trauma, overly negative thoughts and assumptions about oneself or the world, exaggerated blame of self or others in relation to the trauma, persistent negative affect, decreased interest in activities once enjoyed, feeling isolated or cut off from others, and/or difficulty experiencing positive affect); and
- d) at least two symptoms indicating trauma-related arousal and reactivity that began or worsened after the trauma (i.e., irritability or aggression, risky or destructive behavior, hypervigilance, heightened startle reaction, difficulty concentrating, difficulty sleeping).

**Note:** The symptoms must be present for more than a month creating distress or functional impairment (e.g., social, occupational) and not be the result of a medication, substance use, or other illness.

## Annex I (informative)

### Sample internal audit tool

#### Notes:

- 1) This Annex is not a mandatory part of this Standard.
- 2) The following annex is based on Annex E from CAN/CSA Z1003/BNQ 9700-803. It has been modified to include the additional requirements and guidance within this Standard. For the purposes of this audit tool, the term “organization” refers to the “Paramedic service organization”.

#### I.1

Table I.1 is a sample audit tool that may be used by organizations to conduct internal audits. This audit tool may be modified to suit the size, nature, and complexity of the organization. The audit tool may also function as a “gap analysis” tool to highlight those areas that require further work to meet the requirements of this Standard.

Most organizations that implement this Standard will do so over a period of time. This Standard addresses different aspects of the subject at three levels of commitment, from more demanding to less demanding, that will ultimately reflect the maturity of an organization with respect to its ability to implement this Standard:

- a) requirements (expressed with “shall” throughout the body of this Standard), which are mandatory aspects that are required in order to implement this Standard;
- b) recommendations (expressed with “should” throughout the body of this Standard), which suggest aspects that are deemed valuable for full implementation of this Standard but not at the same level as requirements; and
- c) options, which reflect best practices and are considered as “nice to have” parts of the PHSMS.

The column labelled “Level” in Table I.1 indicates those audit questions that relate to the Item categories “a”, “b”, and “c”.

**Table I.1**  
**Sample audit tool**  
(See Clause I.1.)

	Level	Yes	No	Findings	Comments
<b>1. Psychological health and safety management system (PHSMS) policy; leadership; participation</b>					
1.1 Responsibilities and authorities related to the PHSMS must be defined and communicated throughout the organization.	a				
1.2 The organization should ensure that <ul style="list-style-type: none"> <li>• programs for assisting with psychological health and safety of workers are available and accessible</li> <li>• organizational and operational barriers and financial impacts to workers are removed</li> </ul>	b				
1.3 A policy statement (alone or incorporated as part of another relevant policy) endorsed by senior management should refer to psychological health and safety as it applies to the organization.	a				

(Continued)

**Table I.1 (Continued)**

	Level	Yes	No	Findings	Comments
1.4 The policy statement must reflect the organization commitment to <ul style="list-style-type: none"> <li>Establish, promote, and maintain a PHSMS.</li> <li>Align with stated organizational values and ethics.</li> <li>Establish and implement a process to evaluate the effectiveness of the system and implement changes.</li> <li>Delegate the necessary authority to implement the system.</li> <li>Ensure involvement of workers/worker representatives in the development, implementation, and continual improvement of the system.</li> <li>Provide ongoing resources.</li> <li>Ensure regular evaluation and review.</li> <li>Respect the principles of mutual respect and cooperation.</li> </ul>	a				
1.5 Organizational leadership must demonstrate the following qualities: <ul style="list-style-type: none"> <li>Reinforce the development and sustainability of a psychologically healthy and safe workplace environment.</li> <li>Support line management.</li> <li>Establish key objectives for continual improvement.</li> <li>“Walk the talk”.</li> <li>Ensure psychological health and safety is part of decision-making processes.</li> <li>Engage workers/worker representatives.</li> </ul>	a				
1.6 Families and external support systems of workers must be considered through all applicable aspects of the PHSMS.	a				
1.7 The organization must ensure participation through <ul style="list-style-type: none"> <li>engaging stakeholders in regular dialogue;</li> <li>engaging workers/worker representatives in policy development, data generation, and planning;</li> <li>encouraging worker/worker representative participation in programs;</li> <li>encouraging worker/worker representative participation in the evaluation process; and</li> <li>ensuring results of the evaluation process are communicated and follow-up action plans are available.</li> </ul>	a				
1.8 The organization must engage the OHS committee/ worker representatives in defining their involvement in the PHSMS.	a				
1.9 Confidentiality of persons must be respected, including removal of identifying material on relevant documents.	a				
1.10 The organization must <ul style="list-style-type: none"> <li>establish, implement, and sustain policies, programs, and processes that ensure confidentiality and privacy rights are respected and protected within the applicable territorial, provincial, and federal legislation;</li> <li>respect a worker’s request to release his/her personal health information in the organization’s custody; and</li> <li>ensure that confidentiality is maintained for any internal or external auditing personnel.</li> </ul>	a				
1.11 The organization must not have the ability (real or perceived) to access the workers’ confidential health information without informed written consent.	a				

*(Continued)*

**Table I.1 (Continued)**

	Level	Yes	No	Findings	Comments
1.12 The organization has considered development of a specific PHSMS Committee.	c				
1.13 The organization must encourage worker/worker representative participation by <ul style="list-style-type: none"> <li>providing time and resources to participate in the PHSMS program;</li> <li>identifying and removing barriers to participation; and</li> <li>involving and training in relevant aspects of the PHSMS.</li> </ul>	a				
<b>2. Planning</b>					
2.1 The organization's planning process must include <ul style="list-style-type: none"> <li>plans to manage workplace psychological health and safety, including assessment of worker health impact, financial impact and organizational policy/processes promoting good psychological health;</li> <li>a collective vision of a psychologically healthy workplace with specific goals for reaching the vision and a plan for ongoing process monitoring for continual improvement;</li> <li>assessment of the strengths of the existing psychological health and safety strategy; and</li> <li>recognition and identification of current practices that are already protecting and promoting psychological health and safety.</li> </ul>	a				
2.2 The organization must review its workplace policies and procedures on return to work and stay at work.	a				
2.3 The organization must develop, implement, and maintain an individualized and flexible return-to-work and stay-at-work program as part of the PHSMS, in conjunction with any territorial, provincial, and federal regulation and legislation, and any applicable employment contracts.	a				
2.4 The following steps must be incorporated within the organization's return-to-work program and stay-at-work program <ul style="list-style-type: none"> <li>development of a worker-centered return-to-work and stay-at-work plan;</li> <li>scheduling of regular follow-up meetings, to review the progress of the worker and ensure that plans are put into place that meet the needs of the individual, and that the plans are modified accordingly;</li> <li>assist and support with return-to-practice assessment with an occupational competency evaluation, including continuing medical education (CME) sessions, certification renewal, reactivation, and initiation;</li> <li>supporting workers by openly and clearly communicating with them about any income variances they might encounter throughout the return-to-work and stay-at-work process; and</li> <li>sharing the return-to-work and stay-at-work policies and processes with workers throughout their career.</li> </ul>	a				
2.5 The return-to-work and stay-at-work plan must be <ul style="list-style-type: none"> <li>individualized according to restrictions, accommodations, limitations, and abilities; and</li> <li>flexible, graduated, and modifiable;</li> </ul>	a				

*(Continued)*

**Table I.1 (Continued)**

	Level	Yes	No	Findings	Comments
2.6 The organization must review its approach to managing and promoting psychological health and safety in the workplace and to assess conformance with the requirements and recommendations in this Standard.	a				
2.7 The organization must have a defined data collection process that respects privacy requirements.	a				
2.8 The organization must maintain a record of all data collected and information on its sources and share results as required with the OHS committee.	a				
2.9 The organization makes use of multiple sources of data in their planning process.	c				
2.10 The data collection process must ensure that privacy is protected by removal of personal identifiers and aggregation of data.	a				
2.11 The organization must have a system for data collection to track worker exposure to trauma over time to help identify workers at risk.	a				
2.12 The system for data collection should include <ul style="list-style-type: none"> <li>• tracking of exposure to critical events and potentially traumatic events;</li> <li>• system for early identification of worker needs and engagement to the appropriate mental health resources, both formal and informal (e.g., peer support, wellness checks, EFAP, supervisor contact); and</li> <li>• information to workers on how their privacy is maintained within the system.</li> </ul>	b				
2.13 The organization must develop, implement, and maintain a risk management process that includes <ul style="list-style-type: none"> <li>• hazard identification and processes to eliminate hazards where possible;</li> <li>• risk assessment for each identified hazard;</li> <li>• preventive and protective measures to control risks; and</li> <li>• a priority process reflecting the size, nature, and complexity of the hazard and risk and also, where possible, respecting the traditional hierarchy of risk control.</li> </ul>	a				
2.14 The organization must assess their occupational health management system for compatibility with the requirements of this Standard.	a				
2.15 The following factors have been assessed: <ul style="list-style-type: none"> <li>• psychological support;</li> <li>• organizational culture;</li> <li>• clear leadership and expectations;</li> <li>• civility and respect;</li> <li>• psychological job demands;</li> <li>• growth and development;</li> <li>• recognition and reward;</li> <li>• involvement and influence;</li> <li>• workload management;</li> <li>• engagement;</li> <li>• work/life balance;</li> </ul>	c				

*(Continued)*



**Table I.1 (Continued)**

	Level	Yes	No	Findings	Comments
<ul style="list-style-type: none"> <li>psychological protection from violence, bullying, and harassment;</li> <li>protection of physical safety; and</li> <li>other chronic stressors as identified by workers.</li> </ul>					
2.16 The organization should identify and assess opportunities for promoting psychological health.	b				
2.17 The organization should assess chronic/cumulative exposure to critical/stressful events.	b				
2.18 The organization must consider the unique needs of a diverse population and solicit input when these needs are relevant to achieving the goals of this Standard.	a				
2.19 The organization must consider workplace factors that can impact the ability of diverse populations to stay at work or return to work.	a				
2.20 The organization should encourage individual workers to seek assistance internally or externally when needed.	b				
2.21 The organization must take steps to link workers in need to internal resources and should also take steps to link workers to community or other resources.	a, b				
2.22 The organization must document the PHSMS objectives and targets for relevant functions and levels within the organization.	a				
2.23 Objectives and targets should be <ul style="list-style-type: none"> <li>measurable;</li> <li>consistent with the PHSMS policy and commitment to PHSMS, compliance with legal requirements and other requirements, and commitment to continual improvement;</li> <li>based on past reviews, including past performance measures and any work-related psychological health and safety hazards, risks, the result of the data collection, and identification and assessment of psychological workplace factors, management system deficiencies, and opportunities for improvement that have been identified;</li> <li>determined after consultation with workers, consideration of technological options, the organization's operational, and business requirements; and</li> <li>reviewed and modified according to changing information and conditions, as appropriate.</li> </ul>	b				
2.24 The organization's objectives and targets should reinforce existing strengths and promote new opportunities for improving psychological health and safety.	b				
2.25 The organization must establish and maintain a plan for achieving its objectives and targets, including <ul style="list-style-type: none"> <li>designation of responsibility for achieving objectives and targets; and</li> <li>identification of the means and time frame within which the objectives and targets are to be achieved.</li> </ul>	a				

*(Continued)*

**Table I.1 (Continued)**

	Level	Yes	No	Findings	Comments
2.26 The organization must establish, implement, and maintain a system to manage changes that can affect psychological health and safety.	a				
2.27 Care should be taken to ensure managers are included in training or support regarding management of change activities.	b				
2.28 Managers and supervisors should be provided change management information in advance of their staff.	b				
2.29 The system in Item 2.26 should include aspects on <ul style="list-style-type: none"> <li>• communication between stakeholders about the changes;</li> <li>• information sessions and training for workers and worker representatives; and</li> <li>• support as necessary to assist workers in adapting to changes.</li> </ul>	b				
<b>3. Implementation and operation</b>					
3.1 The organization must provide and sustain the infrastructure and resources needed to achieve conformity with this Standard.	a				
3.2 The organization should recognize that <ul style="list-style-type: none"> <li>• workplace parties possess sufficient authority and resources to fulfill their duties related to this Standard;</li> <li>• workplace parties possess the knowledge, authority, and abilities to integrate psychological health and safety into management systems, operations, processes, procedures, and practices; and</li> <li>• persons with roles as specified in this Standard possess knowledge, skills, and abilities to carry out their roles (e.g., auditing, training, assessment, analysis).</li> </ul>	b				
3.3 The organization utilizes internal or external mental health services where there is a quality assurance process for the mental health professional's performance.	c				
3.4 The organization establishes and sustains processes to implement preventive and protective measures to address the identified hazards and risks.	a				
3.5 The organization has implemented preventive and protective measures that reflect the following priorities: <ul style="list-style-type: none"> <li>• eliminating the hazard;</li> <li>• implementing controls to reduce the risks related to hazards that cannot be eliminated;</li> <li>• implementing use of personal protective equipment in applicable circumstances; and</li> <li>• implementing processes to respond to and provide support for issues that can impact psychological health and safety, whether they relate to organizational factors, or to other factors, such as personal factors.</li> </ul>	a				
3.6 The organization must establish and sustain processes for preventive, evidence-informed workplace interventions and ensure these interventions are available to all workers.	a				
3.7 Workplace interventions should include <ul style="list-style-type: none"> <li>• monitoring exposure to trauma and chronic stressors;</li> </ul>	b				

*(Continued)*

**Table I.1 (Continued)**

	Level	Yes	No	Findings	Comments
<ul style="list-style-type: none"> <li>• system for early identification of worker needs and engagement to the appropriate mental health resources;</li> <li>• orientation for new workers including mental health awareness and training;</li> <li>• programs to build and strengthen resiliency skills;</li> <li>• proactive outreach to those who might exhibit concerning changes in behaviour;</li> <li>• peer support programs;</li> <li>• post-trauma support (early and ongoing); and</li> <li>• self-care promotion and support (work-life balance, nutrition, fitness, etc.).</li> </ul>					
3.8 The organization must develop, implement, and maintain an evidence-informed psychological health and safety awareness and stigma reduction program including acceptable workplace behaviours.	a				
3.9 The organization must ensure all workers are provided with psychological health and safety awareness and stigma reduction training and education.	a				
<b>(Psychological wellness check)</b> 3.10 The organization should establish, implement, and maintain a psychological wellness check process for all identified at risk workers.	b				
3.11 The psychological wellness check process should be <ul style="list-style-type: none"> <li>• easily accessible to workers as applicable;</li> <li>• conducted by a regulated mental health professional (see Annex G);</li> <li>• carried out upon entry to work to provide a baseline; and</li> <li>• carried out as a regular follow-up to assess coping skills and strategies and to encourage positive mental health.</li> </ul>	b				
3.12 In addition to the identification of hazards and risk factors, organizations should identify and strengthen protective factors, such as <ul style="list-style-type: none"> <li>• sense of community: feelings of belonging or emotional attachment by identifying, establishing, and maintaining acceptable behaviours that are supportive and inclusive of a psychologically healthy and safe workplace;</li> <li>• collective efficacy: perception of a group's ability to achieve intended objectives;</li> <li>• self-efficacy: perception of an individual's ability to achieve intended objectives;</li> <li>• positive coping strategies: ability to constructively manage stress; and</li> <li>• compassion satisfaction: positive feelings from helping someone and feeling valued.</li> </ul>	a				
3.13 The organization must develop, implement, and maintain an evidence-informed suicide awareness, prevention, intervention, and post-vention program integrated within the PHSMS.	a				
3.14 At a minimum, the organization must ensure all workers are provided with awareness training and education in the area suicide prevention, precipitants of suicidality, and pre-existing mental health difficulties, etc.	a				

*(Continued)*

**Table I.1 (Continued)**

	Level	Yes	No	Findings	Comments
3.15 The organization must establish and sustain processes to <ul style="list-style-type: none"> <li>provide information about factors in the workplace that contribute to psychological health and safety, and how to reduce hazards and risks that potentially cause psychological harm, and how to enhance factors that promote psychological health;</li> <li>ensure stakeholder education, awareness, and understanding of the nature and dynamics of stigma, psychological illness, safety, and health;</li> <li>communicate to stakeholders existing policies and available supports;</li> <li>communicate to stakeholders processes available when issues can impact psychological health and safety;</li> <li>communicate to stakeholders information about the psychological health and safety system and related plans and processes; and</li> <li>include stakeholder ideas, concerns, and input for consideration. Ensure communication throughout the monitoring and review process (see Clause 4.5) to all workplace parties.</li> </ul>	a				
3.16 The organization must encourage and support workers in recognizing their responsibilities for maintaining their own psychological health and positively contributing to the well-being of those around them.	a				
3.17 Organizations must ensure that psychological health and safety education and training opportunities are made available to workers throughout all stages of employment, from the recruitment stage through retirement.	a				
3.18 Organizations must provide access to information regarding mental health to the families of workers.	a				
3.19 Families of workers must have access to information on <ul style="list-style-type: none"> <li>early warning signs of potential operational stress injuries; and</li> <li>mental health resources that are available to workers and families of workers and how they can be accessed.</li> </ul>	b				
3.20 Communication regarding psychological health and safety initiatives should be extended to families of workers.	b				
3.21 The organization should consider making opportunities for mental health education and training available to families.	b				
3.22 The organization has established processes to support effective and sustained implementation, including <ul style="list-style-type: none"> <li>sponsorship by senior leadership and leadership at all levels of the organization;</li> <li>engagement on the part of stakeholders; and</li> <li>assessment and application of change management principles throughout planning and implementation.</li> </ul>	a				
3.23 The organization must establish <ul style="list-style-type: none"> <li>clear responsibilities and accountabilities for effective implementation;</li> <li>governance processes that support effective implementation and communication plans; and</li> </ul>	a				

*(Continued)*

**Table I.1 (Continued)**

	Level	Yes	No	Findings	Comments
• documentation requirements.					
3.24 The organization must establish and sustain processes that ensure confidentiality and privacy rights are respected and protected.	a				
3.25 The organization must <ul style="list-style-type: none"> <li>• establish, implement, and sustain policies, programs, and processes that ensure confidentiality and privacy rights are respected and protected within the applicable territorial, provincial, and federal legislation;</li> <li>• respect a worker's request to release his/her personal health information in the organization's custody; and</li> <li>• ensure that confidentiality is maintained for any internal or external auditing personnel.</li> </ul>	a				
3.26 The organization must not have the ability (real or perceived) to access the workers' confidential health information without informed written consent.	a				
3.27 The collection, storage, maintenance, disclosure, and destruction of confidential health information must meet or exceed the applicable territorial, provincial, and federal confidentiality and privacy legislation.	a				
3.28 The organization must establish and sustain ongoing resources to <ul style="list-style-type: none"> <li>• determine expectations and minimum requirements of workers and in particular those in leadership roles (e.g., supervisors, managers, workers representatives, union leadership) to prevent psychological harm, promote psychological health of workers, and address problems related to psychological health and safety; and</li> <li>• provide orientation and training to meet requirements for Clause 4.4.6.</li> </ul>	a				
3.29 Workers and managers should receive training that informs, builds competencies and skills, and promotes overall psychological health and safety in a workplace context.	b				
3.30 Training in the following areas should be considered within a PPHSMS, including but not limited to <ul style="list-style-type: none"> <li>• crisis management;</li> <li>• mental health problem awareness and prevention;</li> <li>• mental health promotion; and</li> <li>• conflict management skills.</li> </ul>	b				
3.31 Organizations should consider providing train-the-trainer opportunities to workers in order to have training delivered by those familiar with the paramedic community.	b				
3.32 The organization should provide additional training and awareness to those individuals taking on the role of mentor or preceptor to assist in the protection of the psychological health and safety of workers.	b				
3.33 The organization should have a process to support the transfer of skills, knowledge, and attitudes into the workplace in the area of stigma reduction.	b				

*(Continued)*

**Table I.1 (Continued)**

	Level	Yes	No	Findings	Comments
3.34 The organization should establish and sustain processes to <ul style="list-style-type: none"> <li>provide accessible coaching and supports as required, recognizing the potential complexities of psychological health and safety situations, the unique needs of the individuals affected, and the skills needed; and</li> <li>assess and address competence of those in leadership roles specific to Item 3.28.</li> </ul>	b				
3.35 The organization must establish and sustain processes to <ul style="list-style-type: none"> <li>identify potential critical events where psychological suffering, illness, or injury is involved, or likely to occur, while respecting confidentiality and privacy of all parties;</li> <li>provide response and support, including consideration of specialized external supports;</li> <li>provide related training for key personnel involved in critical event response; and</li> <li>ensure there are opportunities for debriefing and for revising guidelines for critical events as applicable.</li> </ul>	a				
3.36 Organizations must be prepared with critical event response plans.	a				
3.37 Critical event response plans must be communicated and accessible in advance to all parties within the organization.	a				
3.38 Organizations must ensure that psychological health and safety support is included in the development of the individual and organizational critical plans.	a				
3.39 Organizations must consider factors and stressors that are both internal and external to the workplace that can contribute to stronger individual responses to individual critical events.	a				
3.40 The individual critical event process should also include <ul style="list-style-type: none"> <li>how the critical event process is activated;</li> <li>how the organization will ensure a worker-focused response; and,</li> <li>consideration for reactions to atypical events and repeat exposures.</li> </ul>	b				
3.41 The individual critical event process should be developed and maintained in collaboration with a subject matter expert.	b				
3.42 To complement critical event support initiatives offered internally by the organization, organizations should consider providing an option for workers to access independent, external support.	b				
3.43 The organization must establish and sustain processes to <ul style="list-style-type: none"> <li>ensure the psychological health and safety risks and impacts of critical events are assessed;</li> <li>manage critical events in a manner that reduces psychological risks to the extent possible and that supports ongoing psychological safety;</li> </ul>	a				

*(Continued)*

**Table I.1 (Continued)**

	Level	Yes	No	Findings	Comments
<ul style="list-style-type: none"> <li>incorporate learnings from critical events into established plans related to the psychological health and safety system; and</li> <li>ensure there are opportunities for reviewing and for revising guidelines for critical events as applicable.</li> </ul>					
3.44 The organization must ensure that psychological health and safety support is included in the development of their emergency plans.	a				
3.45 Organizations should consider psychological health and safety mutual aid agreement(s) for extraordinary events.	b				
<p>3.46 The organization must establish and maintain procedures for reporting and investigating work-related psychological health and safety incidents. These procedures must include</p> <ul style="list-style-type: none"> <li>establishing roles and responsibilities of all parties participating in the investigation process;</li> <li>practices that foster a psychologically safe environment that allows workers to report errors, hazards, adverse events, and close calls;</li> <li>a commitment to appropriate accountability, looking first at system factors that contributed to the error or adverse event;</li> <li>actions to mitigate any consequences of work-related psychological injuries, illnesses, acute traumatic events, chronic stressors, fatalities (including suicides), attempted suicides, and psychological health and safety incidents;</li> <li>the identification of the immediate and underlying cause (s) of such incidents and the implementation of recommended corrective and preventive actions; and</li> <li>an assessment of effectiveness of any preventive and corrective actions taken.</li> </ul>	a				
<p>3.47 Work-related psychological health and safety incident investigations should</p> <ul style="list-style-type: none"> <li>be carried out by persons who are experienced in psychological injury and incident investigation;</li> <li>be carried out by persons impartial and who are perceived to be impartial by all parties;</li> <li>be carried out with the participation of the appropriate workplace parties; and</li> <li>respect the privacy and confidentiality of involved parties, and other relevant legislation.</li> </ul>	b				
3.48 Investigations of cause(s) of work-related psychological health and safety incidents must identify any failures in the PHSMS and must be documented.	a				
3.49 Recommendations must be developed and, along with the investigation's results, must be communicated to the workplace parties.	a				
3.50 Recommendations must form the basis of corrective action and must be included in the management review process and contribute to the continual improvement of the PHSMS.	a				

*(Continued)*

**Table I.1 (Continued)**

	Level	Yes	No	Findings	Comments
3.51 The organization must establish and sustain processes to <ul style="list-style-type: none"> <li>• make external parties and their personnel aware of the organization's policies and expectations related to protecting the psychological health and safety of the organization's workers; and</li> <li>• address any issues or concerns identified.</li> </ul>	a				
3.52 If the organization is involved in referral to mental health professionals, the organization should ensure such professionals have trauma treatment training and OSI training.	b				
3.53 Mental health professionals should have experience with first responders, preferably with paramedics.	b				
<b>4. Evaluation and corrective action</b>					
4.1 The organization must establish and maintain procedures to monitor, measure, and record psychological health and safety and the effectiveness of the PHSMS, respecting the confidentiality and privacy of all individuals.	a				
4.2 The organization must assess organizational conformance to this Standard, including an evaluation of the processes associated with the implementation of this Standard.	a				
4.3 The organization's performance monitoring and measurement approach <ul style="list-style-type: none"> <li>• determines the extent to which the PHSMS policy, objectives, and targets are being met;</li> <li>• provides data on PHSMS performance and results;</li> <li>• determines whether the day-to-day arrangements for hazard and risk identification, assessment, minimization, and elimination or control are in place and operating effectively; and</li> <li>• provides the basis for decisions about improvements to psychological health and safety of the workplace and the PHSMS.</li> </ul>	a				
4.4 Qualitative and quantitative measures (appropriate to the needs, size, and nature of the organization) must be developed in consultation with workers (and, where applicable, their representatives) and must be carried out by competent persons.	a				
4.5 Monitoring and measuring results must be recorded and include the following, as applicable: <ul style="list-style-type: none"> <li>• leadership engagement with the PHSMS;</li> <li>• baseline assessment of psychosocial risk factors;</li> <li>• baseline assessment of other workplace determinants of psychological health (e.g., environmental, physical, job requirement, staffing levels);</li> <li>• psychological injury and illness statistics;</li> <li>• return-to-work programs;</li> <li>• aggregated data from health risk assessments; and</li> <li>• aggregated analysis of the results of investigations or events.</li> </ul>	a				

*(Continued)*



**Table I.1 (Continued)**

	Level	Yes	No	Findings	Comments
4.6 The organization must establish and maintain an internal audit program to conduct audits at planned intervals to determine whether the PHSMS <ul style="list-style-type: none"> <li>conforms to the requirements of this Standard and to the psychological health and safety system requirements established by the organization; and</li> <li>is effectively implemented and maintained.</li> </ul>	a				
4.7 The internal audit program must include criteria for <ul style="list-style-type: none"> <li>auditor competency;</li> <li>the audit scope;</li> <li>the frequency of audits;</li> <li>the audit methodology; and</li> <li>reporting requirements.</li> </ul>	a				
4.8 The audit results, audit conclusions, and any corrective action plan must be documented and communicated to affected workplace parties, including workers and worker representatives, and those responsible for corrective action.	a				
4.9 The organization must consult with workers and, where applicable, their representatives on auditor selection, the audit process, and the analysis of results.	a				
4.10 Management responsible for the activity being audited must ensure that corrective actions are taken to address any non-conformance with the organization's PHSMS or this Standard identified during the audit.	a				
4.11 The organization must establish and maintain preventive and corrective action procedures to <ul style="list-style-type: none"> <li>address PHSMS non-conformances and inadequately controlled hazards and their related risks;</li> <li>identify any newly created hazards resulting from preventive and corrective actions;</li> <li>expedite action on new or inadequately controlled hazards and risks;</li> <li>track actions taken to ensure their effective implementation; and</li> <li>implement initiatives to prevent recurrence of hazards.</li> </ul>	a				
<b>5. Management review</b>					
5.1 The organization must establish and maintain a process to conduct scheduled management reviews of the PHSMS, including <ul style="list-style-type: none"> <li>review and analysis of key outcome data (e.g., audit results, evaluation/outcomes data);</li> <li>assessment of the level of conformance of the PHSMS to this Standard;</li> <li>a detailed review of findings that are considered significant; and</li> <li>organizational and other reporting requirements.</li> </ul>	a				

*(Continued)*

**Table I.1 (Concluded)**

	Level	Yes	No	Findings	Comments
5.2 The review process should address the degree to which the goals of a psychologically healthy and safe workplace are being achieved.	b				
5.3 The outcome of the review process must include <ul style="list-style-type: none"> <li>• opportunities for improvement and, where deficiencies/ variances are identified, corrective actions to be implemented;</li> <li>• review and update of the organizational policies and procedures specific to or related to the PHSMS;</li> <li>• review and update of objectives, targets, and action plans; and</li> <li>• communication opportunities to enhance understanding and application of results.</li> </ul>	a				

## Annex J (informative)

### Resources

**Note:** This Annex is not a mandatory part of this Standard.

#### J.1 General

In helping to inform the development of this Standard, besides the publications listed in Clause 2, a range of other resources was reviewed that provided an understanding of the issues surrounding psychological health and safety in paramedic service organizations.

The resources have been categorized according to type (i.e., standards, policy documents, guidelines and handbooks, peer reviewed research articles, non-peer-reviewed materials, and additional resources). The source materials are primarily from Canada, but a few from other countries have been included. For the purposes of this Standard, Canadian sources were the primary documents considered. This is not a comprehensive resource list on the subject of paramedic mental health, but does provide an inventory of the various reference materials reviewed for the development of this Standard.

#### J.2 List of resources

##### Standards

BSI Publicly Available Specification (PAS) 1010. 2011. *Guidance on the Management of Psychosocial Risks in the Workplace*.

##### Policy documents

Alberta College of Paramedics:

<http://www.collegeofparamedics.org/practitioners/policies-and-bylaws/>

Mental Health Commission of Canada and the Public Services Health & Safety Association (2015). *Supporting the Mental Health of Ontario's Emergency Services Workers Summary*

Paramedic Association of Canada:

<http://www.paramedic.ca/site/nocp?nav=02>

Paramedic Chiefs of Canada:

<http://www.paramedicchiefs.ca/policies/>

Paramedics and EMA Jurisdictional Review:

[http://www.hprac.org/en/projects/resources/ParamedicsandEMAJurisdictionalReview\\_EN\\_2013\\_04\\_02.pdf](http://www.hprac.org/en/projects/resources/ParamedicsandEMAJurisdictionalReview_EN_2013_04_02.pdf)

##### Guidelines and handbooks

CSA Group. 2014. *Assembling the Pieces: An Implementation Guide to the National Standard for Psychological Health and Safety in the Workplace*.

Consortium for Organizational Mental Healthcare (COMH). 2009. *Guarding Minds @ Work*. Faculty of Health Sciences, Simon Fraser University.

#First Responders First Toolkit, 2016:

<http://www.firstrespondersfirst.ca/>

Harvey, S. and Bryant, R. 2015. *Expert Guidelines: Diagnosis and treatment of post-traumatic stress disorder in emergency service workers*. Black Dog Institute: University of New South Wales.

Mental Health Commission of Canada. 2012. *Psychological Health and Safety in the Workplace: An Action Guide for Employers*.

National EMS Management Association 2016. *Mental Health and Stress in Emergency Medical Services*.

U.S. Department of Health and Human Services. 2005. *A Guide to Managing Stress in Crisis Response Professions*.

World Health Organization (WHO). 1998. *Health Promotion Glossary*.

### Peer-reviewed research articles

Donnelly, E. A., Bradford, P., Davis, M., Hedges, C., and Klingel, M. 2015. Predictors of posttraumatic stress and preferred sources of social support among Canadian paramedics. *Canadian Journal of Emergency Medicine, FirstView*, 1-8.

Drewitz-Chesney, C. 2012. Posttraumatic Stress Disorder Among Paramedics: Exploring a New Solution With Occupational Health Nurses Using the Ottawa Charter as a Framework. *Workplace Health & Safety*, 60(6).

Halpern, J., Gurevich, M., Schwartz, B., and Brazeau, P. 2009a. Interventions for critical incident stress in emergency medical services: A qualitative study. *Stress Heal*, 25: 149.

Halpern, J., Gurevich, M., Schwartz, B., and Brazeau, P. 2009b. What makes an incident critical for ambulance workers? Emotional outcomes and implications for intervention. *Work Stress*, 23: 173 – 189.

Halpern, J., Maunder, R., Schwartz, B., and Gurevich, M. 2011. Identifying risk of emotional sequelae after critical incidents. *Emerg Med J*, 28: 51–56.

Halpern, J., Maunder, R., Schwartz, B., and Gurevich, M. 2012. The critical incident inventory: characteristics of incidents which affect emergency medical technicians and paramedics. *BMC Emergency Medicine*, 12(11): 10.

Halpern, J., Maunder, R.G., Schwartz, B. and Gurevich, M. 2014. Downtime after critical incidents in emergency medical technicians/paramedics. *BioMed Research International*.

Leblanc, V.R., Regehr, C., Birze, A., King, K., Scott, A.K., MacDonald, R., and Tavares, W. The association between posttraumatic stress, coping and acute stress response in paramedics. *Traumatology*, 17(4): 10-16.

Maunder, R. G., Halpern, J., Schwartz, B., and Gurevich, M. 2011. Symptoms and responses to critical incidents in paramedics who have experienced childhood abuse and neglect. *Emergency Medicine Journal*.

Regehr, C. 2001. Crisis debriefing groups for emergency responders: Reviewing the evidence. *Brief Treatment and Crisis Intervention*, 1: 87-100.

Regehr, C. 2005. Bringing the trauma home: Spouses of paramedics. *Journal of Loss and Trauma*, 10(2): 97-114.

Regehr, C., Goldberg, G., Glancy, G. D., and Knott, T. 2002. Posttraumatic symptoms and disability in paramedics. *Canadian Journal of Psychiatry*, 47(10), 953-958.

Regehr, C., Goldberg, G., and Hughes, J. 2002a. Exposure to human tragedy, empathy, and trauma in ambulance paramedics. *American Journal of Orthopsychiatry*, 72(4), 505-513.

Regehr, C., Goldberg, G., and Hughes, J. 2002b. Exposure to human tragedy, empathy, and trauma in ambulance paramedics. *Am J Orthopsychiatry*, 72: 505-513.

Regehr, C., Hill, J., Goldberg, G., and Hughes, J. 2003. Postmortem inquiries and trauma responses in paramedics and firefighters. *Journal of Interpersonal Violence*, 18(6), 607-622.

Regehr, C., and Millar, D. 2007. Situation critical: High demand, low control, and low support in paramedic organizations. *Traumatology*, 13: 49-58.

### **Non-peer-reviewed materials**

Canadian Institute for Public Safety Research and Treatment. 2016. *Peer Support and Crisis-Focused Psychological Intervention Programs in Canadian First Responders: Blue Paper*.

Crampton, D.J. 2012. *Comparison of PTSD and compassion fatigue between urban and rural paramedics*. Phd Dissertation – University of the Rockies.

Dunlap, H. E., Couperthwaite, L. M. Z., and Lee, V. 2017. Mental health wellness check-ups and self-care action plans. Presentation at the Tema Conter Memorial Trust Educational Conference, Vaughan, Ontario, Canada.

Halpern, J., and Maunder, R. G. 2011. Acute and chronic workplace stress in emergency medical technicians and paramedics. In J. Langan-Fox and C. L. Cooper (Eds.), *Handbook of Stress in the Occupations*. Northampton, MA: Edward Elgar Publishing: 135-156.

Marmar, C. 2006. *San Francisco Veterans Affairs Medical Centre: Predictors of Post traumatic Stress in Police and Other First Responders*.

Mental Health Commission of Canada. *Guidelines for Recovery Oriented Practice*.

Mental Health Commission of Canada. *Mental disorders and their association with perceived work stress: An investigation of the 2010 Canadian Community Health Survey*.

Mental Health Commission of Canada. *Reducing the Stigma of Mental Disorders at Work: A Review of Current Workplace Anti-Stigma Intervention Programs*.

Mitchell, J.T. 2003. *Crisis Intervention and CISM: A Research Summary*.

Paramedic Association of Canada 2014. *Stress-Related Mental Health Issues in Paramedics and Their Families*.

Paramedic Association of Canada 2015. *Mental Health Wellness Survey*.

Paramedic Chiefs of Canada 2014. *Operational Stress Injury in Paramedic Services: A Briefing to the Paramedic Chiefs of Canada*.

Regehr, C., and Bober, T. 2005. *In the line of fire: Trauma in the emergency services*. New York: Oxford University Press.

**Additional resources**

Association québécoise de prévention du suicide

- <http://www.aqps.info/>

Bell Canada — *Let's Talk Toolkit*

- [letstalk.bell.ca](http://letstalk.bell.ca)

Canadian Association for Suicide Prevention

- <https://suicideprevention.ca/need-help/>

Canadian Centre for Occupational Health and Safety

- <https://www.ccohs.ca/>
- *Healthy Minds at Work*
  - [occohs.ca/healthyminds](http://occohs.ca/healthyminds)

Canadian Institute of Public Safety Research & Treatment (CIPSRT)

- <https://www.cipsrt-icrtsp.ca/>
- Anonymous Self-assessment Mental Health Screening Tool

Canadian Mental Health Association

- [www.cmha.ca](http://www.cmha.ca)
- Mental Health Awareness Week – [mentalhealthweek.cmha.ca](http://mentalhealthweek.cmha.ca)

Canadian Psychological Association

- <http://www.cpa.ca/>
- Finding a psychologist for you
  - <http://www.cpa.ca/public/findingapsychologist/>

Centre for Addiction and Mental Health

- [www.camh.ca](http://www.camh.ca)

Department of National Defence & Canadian Armed Forces, *Road to Mental Readiness (R2MR)*

- <http://www.forces.gc.ca/en/caf-community-health-services-r2mr/index.page>

Excellence Canada

- [excellence.ca](http://excellence.ca)
- Mental Health at Work Certification Program

Guarding Minds at Work

- <https://www.guardingmindsatwork.ca/>

Health Canada

- <https://www.canada.ca/en.html>
- Best Practices for Concurrent Mental Health & Substance Use Disorders
  - <https://www.canada.ca/en/health-canada/services/health-concerns/reports-publications/alcohol-drug-prevention/best-practices-concurrent-mental-health-substance-abuse-disorders.html>

Living Works — Applied Suicide Intervention Skills Training (ASIST)

- <https://www.livingworks.net/programs/asist/>

Mental Health Commission of Canada

- <https://www.mentalhealthcommission.ca/English/>

#### Mental Health Works

- <http://www.mentalhealthworks.ca/>
- Mental Health First Aid: <https://www.mentalhealthcommission.ca/English/focus-areas/mental-health-first-aid>

#### Occupational Health Clinics for Ontario Workers – OHCOW

- <http://www.ohcow.on.ca/>
- Mental Injury Toolkit – [ohcow.on.ca/mit](http://ohcow.on.ca/mit)

#### The Royal Ottawa Hospital (ROH)

- <http://www.theroyal.ca/mental-health-centre/mental-health-programs/areas-of-care/suicide-prevention/>

#### TEMA

- <https://www.tema.ca/>

#### Working Minds & the Carson J Spencer Foundation

- [http://suicideprevention.ca/wp-content/uploads/2014/05/Suicide-and-Workplace\\_white\\_paper\\_responsibility.pdf](http://suicideprevention.ca/wp-content/uploads/2014/05/Suicide-and-Workplace_white_paper_responsibility.pdf)

#### Workplace Strategies for Mental Health (A Great-West Life Initiative)

- [workplacestrategiesformentalhealth.com](http://workplacestrategiesformentalhealth.com)

