

**Mental health and psychosocial calls in the prehospital setting in Ontario:
A qualitative case study**

Polly Ford-Jones

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**Graduate Program in Health
York University
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Abstract

Paramedics have seldom been included in discussions of mental health care and yet play a significant role in the chain of mental health care for many. This thesis explores the nature of paramedic work and the mental health and psychosocial calls encountered by paramedics in the community. This project is a case study of mental health and psychosocial calls in paramedicine in Ontario and was designed to explore the care provided by paramedics on mental health and psychosocial calls, the training and resources for these calls, and the experiences of paramedics in managing these calls. Using both a feminist political economy and social determinants of health approach, this thesis explores questions around care provision on the front lines, but also beyond into community mental health services and to the social determinants of health impacting an individual's need for care from paramedic services. I conducted interviews with front-line paramedics, paramedic services management, paramedic educators and Base Hospital physicians/managers; observation in three paramedic services including urban, rural/suburban and rural with varying degrees of engagement on the issue of mental health in paramedicine; and document analyses of the standards guiding paramedic practice in this area. This thesis reframes issues of mental health calls in paramedicine from an issue of "misuse" of emergency services, to one which accounts for the contexts creating distress as well as existing constraints for work and care. Findings from this study support enhanced training and education for paramedics, specific mental health related programming for paramedic services, as well as the importance of working conditions for both care providers and care recipients. I argue that there must be a balance between efforts placed on establishing appropriate supports for managing mental health and psychosocial calls as well as addressing necessary training and education in this area, while simultaneously ensuring sufficient focus remains at the level of prevention at the broader social, political, and economic determinants of physical and mental health.

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Chapter 1: Introduction

1.0 Introduction

As discussions of mental health needs become more prevalent, in news media as well as new areas of academic inquiry, questions arise around the factors leading to these mental health needs, as well the ways in which support and care are provided. For those seeking mental health support, and those in crisis, paramedics have rarely been considered a part of these discussions, and as part of the chain of care (Emond, O'Meara & Bish, 2019; Ford-Jones & Chaufan, 2017; Prener & Lincoln, 2015). In recent years, the media literature in Canada as well as some academic literature (outside of Canada), has identified an increase in calls to paramedic services for mental health and 'psychosocial' issues. As the prevalence of these calls to paramedic services increases, the nature of these calls, as well as the ways in which these calls are addressed warrant further consideration. The brief window of time that paramedics may have with individuals with mental health needs presents a significant and vulnerable period, as well as an important transition in care.

In considering a rise in mental health and psychosocial call volume, questions exist as to what is driving these calls and their increase, an inquiry that is of potential importance to domains beyond that of paramedicine. This inquiry into mental health calls to paramedic services involves questions around care provision on the front lines, but also beyond this into community mental health services and even more broadly, to the social determinants of mental health. These inquiries are impacted by our understanding of what is mental health and mental health equity, and thus what is 'abnormal' mental health and why do mental health needs arise? While understandings of mental health and mental 'disorder' have often been explored at the individual level with biological or physiological explanations, and solutions directed to individuals, focus can be shifted to consider distress as reflective of broader social, economic and political conditions – potentially distress as a reasonable response to 'abnormal' circumstances.

The field of front-line mental health and psychosocial care provided by 9-1-1 paramedic services as emergency response -- including training, available resources, and the conditions in which this care takes place -- must be considered alongside the broader structures and context driving this need for care to address this issue. Using a feminist political economy approach (Armstrong, Armstrong & Coburn, 2001; Bezanson & Luxton, 2006; Braedley & Luxton, 2010; Vosko, 2002), in this dissertation I explore the conditions of work and care in which these 9-1-1

calls to paramedic services take place. I explore the structures that impact the ‘choice’ to seek care from paramedic services such as existent community mental health supports, social services, and limited resources in home and community settings; the structures that impact care that paramedics are able to provide, such as training, practice guidelines and health policy; as well as the contexts and determinants of mental health potentially impacting an individual’s need for care and support from paramedic services. The social determinants of health (SDOH) approach informs an understanding of the factors affecting mental health (Allen, Balfour, Bell & Marmot, 2014; Fisher & Baum, 2010; Larsson, 2013; Marmot, 2005; Mills, 2015; Raphael, 2009b) and situates an individual’s mental health in social and political context, beyond the individual.

This project is a case study of mental health and psychosocial calls in paramedicine within Ontario and was designed to explore the care provided by paramedics on mental health and psychosocial calls, the training and resources for these calls, and the experiences of paramedics in managing these calls. Additionally, the project was designed to explore factors leading to distress and crisis, and leading individuals to activate paramedic services. To do this, I used a critical ethnographic approach (Cresswell, 2009; Thomas, 1993) including observations, interviews and document analysis. This case study asks the following research questions: *In what ways are mental health and psychosocial care managed in the prehospital, paramedic services setting in Ontario? What guides this practice, and to what extent do these services address the social determinants of mental health?* In this chapter, I address the key concepts and terminology employed and outline the contents of the dissertation by chapter.

1.1 Key Concepts and terminology

A review of our understanding of mental health and the causes of distress is critical in order to determine where solutions lay for addressing the concern of high rates of mental health calls and crises, as well as prevention of these calls. Mental health has largely been understood in a biomedical, reductionist framework locating the cause of mental distress at the biological level, focused on genes and neurotransmitters – a ‘disease model’ of mental illness (Bracken & Thomas, 2005; Kinderman, 2015; Kinderman, 2017). Further, even when social circumstances are understood to contribute to distress, mental health is often “purely an individual concern to be managed through self-caretaking, the administration of expert technologies, and where necessary, aggressive health interventions that proceed without any gesture towards the structural

roots of human distress” (Menziés, LeFrançois, & Reaume, 2013, p.16). In contrast to this dominant discourse, there is immense ambiguity in the literature. For instance, moods and behaviours can be defined as ‘abnormal’ or ‘illness’ rather than as variation in human experiences (Kinderman, 2015; Kinderman 2017; Rose, 2003). The hegemonic focus on a biomedical or individualized understanding of mental health draws attention away from the factors contributing to distress such as poverty, lack of housing or adequate housing, unemployment and an extensive range of factors, including personal relationships and histories of trauma (Bracken et al., 2012; Kinderman, 2017; Mills, 2015). Biomedicine claims to have established effective methods for diagnosis, screening and treatment, with heavy reliance on psychiatric services and pharmaceuticals (Morrow & Malcoe, 2017). There is however a lack of analysis of power and the social, political, cultural and economic factors and the ways in which these contribute to understanding mental health problems and solutions (Morrow & Malcoe, 2017).

The call to move away from this reductionist understanding of mental health and distress, toward an understanding that places appropriate emphasis on context and experience, has come from multiple domains in critical social work/ critical mental health, the social sciences as well as psychiatry (Bracken et al., 2012; Kinderman, 2015; Kinderman, 2017; LeFrançois, et al. 2013; Malcoe & Morrow, 2017; Szasz, 1960; Szasz, 1997).

In statistical terms, variance in neurological processes seems to account for very little in terms of mental health – or indeed human behaviour in general. Most of the variability in people’s problems appears to be explicable in terms of their experience rather than genetic or neurobiological malfunctions.

(Kinderman, 2017, p.289)

Kinderman (2017) highlights that despite substantial evidence, the magnitude of social factors’ impact on mental health and distress are sidelined and routine mental health care focuses on treatment of illness, rather than supporting people in addressing these challenges. He states that the post-psychiatry or social psychiatry perspectives highlight that “...the vast majority of mental health problems, including those traditionally seen as symptoms of serious ‘illness’ such as schizophrenia’ should instead be understood from the perspective of social psychiatry - as normal, human, responses to difficult social circumstances” (Kinderman, 2017, p.288). This

perspective is presented by Patrick Bracken and 28 colleagues, (2012) and the President of the World Psychiatric Association, Dinesh Bhugra (Strudwick, 2013). While a critique of psychiatric diagnoses as exclusive of social context and lived experience is not new, most recently, in the academic literature there have been calls to move away from labelling and diagnosing symptoms of distress through Diagnostic and Statistical Manual (DSM) categorization (Allsopp & Kinderman, 2017; Cooke & Kinderman, 2018). It has even been suggested that the circumstances that have given rise to distress ought to be recorded as well as the nature of the distress (ie: symptoms) by mental health professionals – including: adverse life experiences and living environments such as poverty, homelessness, discrimination, as well as histories of trauma. The suggestion is that such an approach may establish more comprehensive data around patterns of challenges leading to distress and documentation of social determinants of mental distress (Allsopp & Kinderman, 2017) as well as avoiding potentially damaging consequences of pathologizing and applying diagnoses to distress resulting from certain life experiences (Cook & Kinderman, 2018). Pathologizing experiences of distress resulting from the realities of living in poverty has additionally been referred to as “The psychiatrization of poverty,” (Mills, 2015).

A SDOH framework supports an understanding of distress as originating from a range of social, political and economic circumstances (Allen, Balfour, Bell & Marmot, 2014; Fisher & Baum, 2010; Larsson, 2013; Raphael 2009a). This approach establishes that those with higher socioeconomic status and better living conditions have better mental health outcomes, and those with lower socioeconomic status and worse living conditions have worse mental health outcomes (Fisher & Baum, 2010; Larsson, 2013). As we understand mental health to be something substantially impacted by living and working conditions, along with life experiences and experiences of trauma, this moves beyond the biomedical, ‘illness’ model of distress and poor mental health. It moves beyond social problems as the fault and responsibility of an individual (Morrow & Malcoe, 2017), shifting our gaze from problems with an individual, to understandable distress, locating both problems and solutions at broader social, political and economic levels.

The study employs broad and inclusive definitions of ‘mental health’ and ‘psychosocial calls’ to work towards better defining these types of calls, as well as aiming to capture areas beyond acute crisis. A paramedic ‘call’ here is described as a 9-1-1 call to which paramedics

respond and may provide care and transport to hospital. The definitions of these mental health and psychosocial calls are explored in Chapter 2 in the dissertation. Broadly stated however, ‘mental health calls’ occur when paramedics provide care to someone with needs that include distress, mental health and substance use, as well as non-medical, non-traumatic health concerns that are not exclusively acute mental health distress, but also are broader social issues, such as homelessness; inadequate access to food; social support needs; unmet support needs for activities of daily living, along with others. Mental health calls may include psychosocial calls and vice versa, however both terms are used to denote distress not specific to medical or traumatic conditions seen by paramedic services but more focused on psychological and social needs of patients. The definitions are expansive and open so as to capture acute mental health crisis and to identify other types of distress that might be addressed to prevent arriving at a point of crisis.

Additionally, while the term ‘patient’ is critiqued in much health and mental health literature and in many mental health settings (Neuberger, 1999; Simmons, Hawley, Gale, Sivakumaran, 2010), use of the term ‘patient’ at different points throughout this dissertation conforms to language used by paramedic services: “an individual for whom a request for ambulance service was made and who a paramedic has made contact with for the purpose of assessment, patient care and/or transport, regardless of whether or not an assessment is conducted, patient care is provided, or the patient is transported by ambulance” (Ministry of Health and Long Term Care, 2017, p. 1). Throughout the dissertation, I will limit the use of the word ‘patient’ when referring specifically to those with mental health needs seeking or requiring care. I will use the term patient when someone is in receipt of paramedic services.

1.2 Contents of the dissertation

In this dissertation, I document the limited literature addressing mental health calls in paramedicine; describe the function and role of paramedics and paramedic services across Ontario; analyse Ontario policies and legislation that govern paramedic services and practices; describe paramedics’ management of and training for mental health and psychosocial calls; describe the gaps in other health and social services resulting in people calling upon paramedic services; describe programs in place to address mental health calls in paramedicine; and discuss the evolving nature of the profession.

Chapter 2 offers a critical inquiry into mental health equity and the methodology guiding this dissertation. The chapter addresses how mental health is conceptualized and the theoretical foundations generating this understanding. I review the feminist political economy framework and SDOH approaches guiding the dissertation. These frameworks situate mental health in context, beyond the individual level by exploring the conditions in which the following occurs: distress; demand for paramedic services; as well as the conditions in which care is provided by paramedics. Equity in mental health is explored, stressing the conditions for equitable mental health; equitable supports for those in distress; and the influence of neoliberal ideology for mental health and social policy. I also include reflexivity of myself as the researcher, as a working paramedic within Ontario.

The qualitative research methods employed in this dissertation are outlined in Chapter 3. I describe the case study design used to explore the case of mental health and psychosocial calls in paramedicine in Ontario through 3 subunits – paramedic services. I describe its suitability for studying mental health and psychosocial care management in paramedicine in Ontario, how practice is guided and how services address the social determinants of health. In outlining the study flow, I describe the ethics process, site sampling criteria, recruitment, and procedures for interviewing, observational research and document analysis. I outline procedures for data analysis and my process of reflexivity by situating myself in this dissertation research.

In Chapter 4, in order to situate the discussion of mental health and psychosocial calls to paramedic services, I describe paramedic work in Ontario in Section 4.2. I provide a brief history of this relatively young profession, as well as outline the nature of the work. I describe the settings in which paramedics provide care; present an overview of the standards of paramedic practice and medical oversight of paramedics; as well as describe the job's physical demands. Subsequently, I describe paramedics' roles; the scope of practice and care they are able to provide; as well as the education and training they receive. I present the current and future directions of paramedicine as it has continued to evolve, touching on community paramedicine and areas of work for paramedics, beyond 9-1-1 emergency medical response.

In Section 4.5, I explore what constitutes paramedic mental health and psychosocial work in Ontario drawing primarily from interviews with front line paramedics, paramedic services management, paramedic educators and base hospital directors/physicians, in addition to observations of paramedic work. This chapter shows that in addition to calls pertaining to

mental health diagnoses, self-harm, suicide and substance use, paramedics frequently describe contexts for distress during ‘mental health calls,’ in particular describing individuals who have a lack of support. These contexts as well as the need for a broad and inclusive definition of mental health calls are discussed in the light of individuals who are activating paramedic services, so as to recognize areas for prevention. The discussion of mental health calls is exemplified by a mental health call in an Ontario city excerpted from field notes.

Chapter 5 reviews and critically analyses the policy guiding paramedic practice in Ontario pertaining to mental health and psychosocial calls, as well as other policies and standards potentially impacting these calls. This chapter explores the limited guidelines and standards for paramedics with regard to mental health and psychosocial calls in Ontario and the challenges with limited guidance and standards to which care is upheld in this area. Health, mental health and social policies such as those leading to deinstitutionalization and movement of mental health services into the community are explored as well as the impact of the neoliberal ideology driving policy shifts. Ultimately, I explore whether paramedic services are the right service to be providing mental health and psychosocial care for those in distress and how this is informed by policy.

In Chapter 6, I present findings of the ways in which policy and guidelines are put into practice for paramedics providing care. I describe the stages of a mental health call for front-line paramedics, from the dispatching of call information through to transferring care at the hospital ED. The ways in which paramedics manage the different components of these calls, as well as the challenges in managing these calls are presented.

Chapter 7 presents the conditions in which care and work are carried out for paramedic care providers and for individuals requiring and/or receiving mental health support with sections on: paramedic services management, workload and paramedic mental health; work care and space; and how care provided in home and community settings differs from institutional, public settings, and also the limitations of mental health care in the ED; work, care and place; and the urban or rural contexts of paramedicine care work. These conditions of work and care are illustrated through the case of a rural mental health transfer. The tensions in work and care such as ensuring both patient and paramedic safety through efforts to mitigate violence, as well as the limitations inherent in different care provision settings such as home, community and the ED are discussed. I problematize discourses of ‘misuse’ of paramedic services for mental health and

psychosocial needs. Additionally, the importance of differentiating mental health needs, support and accessibility in both urban and rural settings are discussed, offering a comparison between regional, service-level sub-units in the case of mental health and psychosocial care in paramedicine in Ontario.

Training and education of paramedics is explored in Chapter 8, including the current requirements as well as the experiences of paramedics and educators in the area of mental health and psychosocial care education. The gaps in training as well as promising practices for training are also discussed. The value placed on different skills and types of work such as emotion work as it applies to mental health and psychosocial care; along with the gendered nature of ‘care work’; and finally, the limitations of education and training are discussed.

Chapter 9 describes projects and programming underway in a select number of paramedic services in Ontario: diversion programs; crisis response teams; and varied community paramedicine initiatives. I also reveal paramedics’ perspectives on the challenges and benefits of these programs. The tensions in addressing increasing mental health and psychosocial care needs through paramedic services programming versus mental health and social policy addressing the social determinants are explored. The role for paramedics in informing broad mental health policy is addressed.

Chapter 10 highlights the importance of a contextual understanding of mental health compared with a biomedical one. I outline the ways in which this study has contributed to mental health discourse through supporting the reframing of mental health to incorporate contextual factors and the SDOH, informing more appropriate care, areas for prevention and ensuring that those suffering the consequences of inadequate social determinants are not blamed for their use of emergency mental health care services, but rather that these gaps in care inform discussion for policy direction and support in other domains. Finally, the contributions to paramedicine are discussed through the need to address paramedic education and training, the value of mental health related programming in paramedic services, implementation of appropriate resources for paramedics addressing mental health and psychosocial needs in the community, and the role of paramedics informing other policy areas for action.

Chapter 2: Methodology: Critical Inquiries in Mental Health

2.0 Introduction

This dissertation explores the nature of mental health and psychosocial “calls” -- when people dial 9-1-1 and receive paramedic services -- asking what factors may be driving distress and mental health needs resulting in call activation? Furthermore, to what extent are the social determinants of mental health addressed by the provision of prehospital paramedic services? I use the term ‘distress’ as an encompassing term that speaks to those experiencing mental health challenges, including those in crisis and those who might have been diagnosed with a ‘mental disorder’ or ‘mental illness’ and will expand on the use of the term below.

The dissertation starts from the premise that paramedics have a unique perspective: they engage with people in their daily living and working conditions, often at acute points of crisis, and may have distinct perspectives on the conditions from which distress may arise. The circumstances observed on these calls by paramedics may shed light on what may be leading to increased mental health call volume, and the factors leading to a point of crisis for individuals in their daily living circumstances (Ford-Jones & Chaufan, 2017). Furthermore, the understanding of mental health and its determinants will be explored in relation to how it is addressed in paramedic training, practice and resources for providing care.

In this chapter I present the methodology – the theory guiding this research, which also informs the choice of research methods. Chapter 3 then presents the research methods carried out in conducting this study. This methodology chapter addresses the theoretical approaches used in this dissertation to understand the conditions for paramedic work; mental health and care; and the potential for mental health equity. First, I present the key assumptions of feminist political economy that I use to explore mental health and psychosocial calls in paramedicine, and the conditions of work and care impacting both the care providers and care recipients. Next, theoretical approaches to understanding mental health and distress are presented, including a SDOH framework that explores social, political, and economic conditions impacting mental health. Also, along with accessibility to appropriate services and supports I present a mental health equity approach that understands equity in social and economic conditions to be imperative for good mental health. I then discuss how I see feminist political economy and the

SDOH frameworks coming together and how I use this as the methodology guiding this study. Finally, I explore reflexivity in research and my assumptions and biases as a researcher.

2.1 Feminist political economy

In this section I outline some of the core tenets of feminist political economy such as the value of understanding daily lived experiences; tensions between structure and agency; the study of paid and unpaid work; the conditions of work and care; and social reproduction. I present these core aspects of this framework as applied to mental health and paramedicine care work.

Political economy is the study of society as “a totality which includes the political, economic, social, and cultural, where the whole is greater than its parts” (Clement, 1997, p.3) “and where these dimensions must be understood in the context of each with the other” (Bezanson & Luxton, 2006, p.12). Feminist contributions to this approach incorporate social locations including class, gender, race, ethnicity and sexuality (Armstrong, Armstrong, & Coburn, 2001), highlight the role of family and the importance of daily lived experiences and context (Smith, 1989) and offer the concept of social reproduction - - the processes involved in maintaining and reproducing people - - as an important analytical tool (Bezanson & Luxton, 2006). Specifically, feminist political economy engages with tensions between structure and agency – identifying how individuals have agency, and the ability to make decisions. They make decisions however, within the constraints of broader systems and structures (Armstrong et al., 2001). In other words, feminist political economy understands individuals, their physical and mental health, in conditions not necessarily of their choosing.

Furthermore, this framework draws attention to tensions between paid and unpaid work, including work that has been shifted from the public to private spheres, onto communities and individuals (Armstrong et al., 2001). Feminist political economy considers the role and context of care providers, those receiving care and the relationships between the two (Armstrong & Braedley, 2013). When studying the conditions of care, a feminist political economy approach considers the training and skills of individuals and groups of care providers, but explores them within the working conditions in which they’re carried out, and with acknowledgment of what limitations this may impose (Armstrong, 2013b). This highlights the tension between the agency of individual care providers and the structural conditions in which they provide care. This

framework shapes the analysis for this dissertation of how the conditions of work and care – as exemplified by mental health paramedicine “calls” – affect patients and paramedics.

In assuming that an individual and their personal mental health occurs within conditions outside of individual choices, this dissertation explores the variety of conditions and structures impacting individuals’ mental health and wellbeing. For instance, in considering those in distress who are activating paramedic services or having paramedic services activated for them, I explore the conditions within which the call originates, such as the circumstances from which distress is arising for that individual, and what is occurring on the scene of these calls. Importantly, to understand the reasons for a call occurring it is also necessary to understand the structure and constraints of the current mental health care system.

The constraints of different structures and systems are essential to consider, when exploring the conditions in which paramedics provide care to individuals in the community. In other words, in order to understand the care paramedics are choosing to provide - - the agency of paramedics - - it is necessary to understand what structures and systems may constrain these ‘choices’ and what limitations exist in the care they provide. For instance, feminist political economists argue that we must explore the training and conditions of work (Armstrong, 2013a & b) and I have applied this approach to the study of paramedics including the conditions constraining paramedicine work, including training paradigms, policies, protocols, and limitations in resources and transport destinations for individuals in crisis.

Social reproduction, as viewed by feminist political economists involves the work of maintaining and reproducing people: “the provision of food, clothing, shelter, basic safety, and health care, along with the development and transmission of knowledge, social values, and cultural practices and the construction of individual and collective identities” (Luxton & Benzanson, 2006, p.3). Feminist political economists have conceptualized care as central to much social provision (Daly & Lewis, 2000), with care conceptualized as a multi-dimensional concept involving labour, obligation and responsibility as well as financial and emotional costs in both public and private domains (ibid). Social care is thus integral to many aspects of social reproduction with implications for individuals’ and communities’ wellbeing. Feminist political economists identify that care work is often gendered and racialized with much of the burden of this work falling onto families, and especially women (Luxton & Benzanson, 2006). Acceptable

conditions for social reproduction and specifically care “will reflect the balance of gender, class, and race/ethnic power relations” (Luxton & Bezanson, 2006, p.4).

Feminist political economists identify the role of neo-liberalism in social reproduction, in the Canadian context, with social policy and responsibility shifted to lower levels of government such as provinces and municipalities. This also often shifts responsibility and thus blame for social needs, as well as solutions to social problems onto families and individuals. Feminist political economists challenge the notion that cuts in social spending for social care needs can successfully or appropriately shift responsibility into private spheres and forms of informal caregiving (Luxton & Benzanson, 2006). Care work has been explored by feminist political economists in terms of both paid and unpaid work, work inside and outside of the home and in other institutions (Day, 2013) and it is shaped by social, political and economic contexts (Daly & Lewis, 2000). Such conceptions of social provision and social care are applicable to understanding the contexts in which people’s mental health and wellbeing occur. Haley (2017) notes that feminist political economy has much to offer to studies of mental health care as related services are a significant part of ‘daily maintenance,’ which is central to social reproduction, and shaped by the prevailing arrangement of production. These care services and other elements of social care are significant components of what may prevent distress, or lead to distress and potentially calls to paramedic services.

Analysis of care work has included study of skills involved in care work, and importantly addressed what are perceived and valued as ‘skills,’ and necessarily the contexts in which they are carried out (Armstrong, 2013b). Skills have been dichotomized as ‘hard’ and ‘soft’ skills. ‘Hard’ skills are seen as hands-on, tangible, and measurable skills, viewed as ‘masculine’ and often performed by men, and ‘soft’ skills, are often viewed as ‘feminine,’ often performed by women, generally less valued, and often less measurable. Feminist political economists contest that despite the generally lesser value placed on ‘soft skills’ and often less time allotted to them, they are a critical component of much care work (Armstrong, 2013a).

Feminist political economy frameworks of analysis have been applied to other health work settings such as long term care (Armstrong & Braedley, 2013), home care settings (Barken et al., 2015), early childhood development settings (Chopra, 2013), women’s health services, services for intellectual disabilities, fire services attending medical calls (Braedley, 2012) and renal dialysis care work (Brassolotto & Daly, 2016). Specifically, feminist political economy

analyses have been applied to mental health care domains including the study of Ontario's public mental health care system (Haley, 2017) caregivers for family members with mental health needs (Hanna, 1998), and mental health nursing (Choiniere, MacDonnell, Campbell & Smele, 2014).

2.2 Understanding mental health: Theoretical approaches

The way in which mental health is conceptualized plays a critical role in where we place focus when trying to further understand it, for instance, whether we look at problems with an individual and their biology, or at living conditions and experiences which impact people's mental health and wellbeing. Furthermore, our understanding of mental health impacts our understanding of what are appropriate forms of mental health care, and even what is equity in mental health. Mental health and 'mental illness' have often been understood in reductionist terms, placing focus on the biological, and on genetics, and neurotransmitters (Bracken & Thomas, 2005) or at least as individualized problems requiring health systems' interventions (LeFrançois et al., 2013; Morrow & Malcoe, 2017). The significance of context in mental health, including personal histories, relationships, cultural and political systems, is a focus that largely arose out of the anti- or post-psychiatry movements and critical social work or critical psychiatry paradigms (Bracken et al., 2012; LeFrançois, et al., 2013). In these subsections I present a contextualized rather than reductionist understanding of mental health and the role of the 'psychosocial' in this understanding.

2.2.1 Shifting focus: From reductionist to contextual understandings of mental health

Using biomedicine as the frame of reference for viewing such problems {with mental health} easily lends itself to ignoring the meaningfulness, importance and moral value of individual experience. We might employ biomedicine as a partial frame, useful at times, but incomplete and inadequate for much of what we want to accomplish.

(McGruder, 2002, p.77)

Movement away from a reductionist understanding of mental health, with problems and 'abnormal behaviours' understood in biological and physiological terms, involves acknowledgment that such understandings are not objective but value laden and exclude a

complex range of factors and circumstances that impact mental health (Bracken & Thomas, 2005). Critical mental health literature challenges dominant conceptions of ‘mental illness’ and ‘mental disorder’ drawing attention to the hegemonic biomedical origins of such conceptions as well as ambiguity in diagnoses (Bracken & Thomas, 2005; Bracken et al., 2012; Burstow, 2013; LeFrançois et al., 2013). Use of terminology such as ‘illness’ and ‘disorder’ may present a person’s distress as abnormal, something that often detracts from distress as a very reasonable response to highly stressful life events and living conditions (Malla, Joobar & Garcia, 2015). Avoiding use of ‘illness’ and ‘disorder’ does not detract from the serious, significant and sometimes debilitating effects of distress and challenges with mental health, but rather ensures that this distress is thought of in context, from the conditions in which it occurs, and does not present such a response as necessarily inappropriate or unreasonable – held to an undefined ‘norm.’

Mills (2015) presents what she identifies as the problem with ‘mental disorder’ as an unquestioned term or concept:

What are currently called ‘mental disorders’ (a) have not always been seen as such, (b) are not understood as such worldwide because they are the products of specific social, cultural, economic, and historical trajectories, (c) are not monolithic, meaning that different experiences and manifestations of distress may have different status in relation to poverty and forms of oppression, and (d) many mental health diagnoses, and the medications that dominate treatment options, are highly disputed and critiqued... A key critique of psychiatric diagnosis and treatment lies in its decontextualization and individualization of distress – where ‘disorder’ is constructed as inside brains rather than ‘outside’ within the political economy.

(Mills, 2015, p. 215)

In her work on language and mental health, Burstow (2013) states that “words cannot be seen as innocent; words could not matter more” (p.81). She notes that challenging the use of ‘mental illness,’ challenges mainstream conceptions of mental illness, and is a part of addressing the psychiatry paradigm in its hegemonic framing of distress and mental health concerns. The term ‘distress’ has been used in place of, or at least alongside ‘mental illness’ or ‘mental disorder’ in works which have focused on the impact of broader conditions affecting mental health, rather than biomedical and genetic origins of mental health issues. In fact, these works

challenge those models as a primary means of understanding mental health (Bracken & Thomas, 2005; Mills, 2015; Morrow & Weisser, 2012). For example, in Morrow & Weisser's work they refer to 'mental distress,' where they discuss the context and experiences of mental distress. They emphasize 'the contributions of social and structural forces' (p.28), exploring the intersection of a range of factors such as racism, sexism and heterosexism. Similarly, Mills (2015) refers often to 'distress,' asking how useful it is to understand distress experienced by those in extremely challenging living conditions, as 'mental disorder' or 'mental illness?' Morrow & Weisser (2012) state that we must resist further trends toward biomedicalism, not to reject *any* role of biology in mental health, but to identify the social context, forms of oppression and erosions of social justice in which the biological take place.

In this dissertation, I use 'distress' so as not to assume that all those individuals who have or have had mental health challenges have necessarily been appropriately diagnosed as 'ill' or 'disordered.' I use this term with a conceptualization of mental health, focused on individuals' experiences rather than a problem located within the individual. Despite the substantial literature and resistance of mainstream conceptions of 'mental illness,' much focus has remained on problems at the level of individuals and their behaviours. Mental health is largely understood as an issue in the domain of the health care system, often medicalized, with the medical field significantly involved in managing mental health (Aho, 2008; LeFrançois et al., 2013; Morrow & Malcoe, 2017). This detracts from the social, political and economic conditions that sustain immensely challenging conditions such as poverty that lead to distress. Diagnostic labels may remain unquestioned, and many of these concerns arising from these circumstances become a medical problem, as do their interventions for management (Mills, 2015). A more comprehensive understanding of mental health, however, explores the multiple layers creating and impacting our mental health and wellbeing, to include the conditions and context in which mental health care and supports are provided.

2.2.1 (a) Including 'psychosocial'

In posing my research question, I refer to both mental health and psychosocial care. As described above, I refer to mental health in a broad and inclusive way, without strict limitations and boundaries of diagnoses. Similarly, I have included the term 'psychosocial' to encompass the range of social issues that may present on calls to paramedics, potentially contributing to

people's distress and their calling 9-1-1. In his discussion of psychosocial care in the paramedic services setting, Brady (2012) refers to looking beyond the physical health needs of patients to the psychological and sociological needs of patients. While doubtless this may encompass mental health needs, it additionally includes social needs. In their discussion of mental health and psychosocial problems in primary care, Bower, Knowles, Coventry & Rowland (2011) refer to problems which may include "diagnosed mental health problems such as depression and anxiety, through to less well defined psychosocial difficulties or 'problems in living,' which may be associated with depression or anxiety symptoms, but may also be linked to financial, domestic or interpersonal pressures" (p.2). In other words, 'psychosocial' is not exclusive of mental health, and 'mental health' may be related to the psychosocial needs of the individual. The use of both 'mental health' and 'psychosocial' care aims to comprehensively explore a broad conception of the mental health-related and social issues paramedics encounter on calls, aligned with the SDOH approach described below.

2.2.2 Social determinants of health

A SDOH framework highlights that health is political and affected by social, political and economic systems. This draws attention to determinants of health that expand beyond the health care system itself. The social determinants arise from a political economy approach, and a focus on the whole rather than the parts (Armstrong et al., 2001) and this approach aims to improve living and working conditions that affect health outcomes (Marmot, 2005). "The social determinants of health are about the quantity and quality of a variety of resources that a society makes available to its members" (Raphael, 2009b, p. 2). These resources are directly linked to health outcomes, rates of disease, and mortality rates.

Mental health is mentioned in the SDOH literature, with "health" encompassing mental health. Specific reference to mental health often focuses on stress resulting from these determinants of health or the rates of mental illness or disorder associated with different determinants (Bambra et al., 2010; Raphael, 2009; Marmot, 2005). A small body of literature draws on the SDOH framework, referring specifically to the social determinants of mental health (Allen et al., 2014; Fisher & Baum; Larsson, 2014; Raphael, 2009a). Here, the same living and working conditions (ie: determinants) ultimately affect both physical and mental health. The literature around the SDOH, including the determinants of mental health, highlight that physical

and mental health follow a gradient, generally that those with higher socioeconomic status and better social, political and economic circumstances have better physical and mental health outcomes (Fisher & Baum, 2010; Larsson, 2013; Marmot, 2005; Mikkonen & Raphael, 2010; Patel, 2010). Those with less favourable conditions and determinants suffer more stress along the life course and are likely to have less buffers, resulting in poorer outcomes (Allen, Balfour, Bell & Marmot, 2014). In terms of the physiological understanding of the determinants, the impact of a prolonged stress response or chronic stress on the body, which occurs as a result of these determinants, can affect physical health and is associated with increased vulnerability to disease and illness (Mikkonen & Raphael, 2010). Stress, and again a prolonged stress response or chronic stress resulting from these determinants, also impacts mental health and wellbeing (Fisher & Baum 2010).

While mental health is mentioned in the SDOH literature and included in “health”, this literature largely identifies rates of mental illness or disorder. For example, living in chronically stressful circumstances and having prolonged stress are associated with anxiety and other conditions such as depression, panic disorder, obsessive-compulsive disorder, sleep disorders, post-traumatic stress disorder (PTSD) and substance misuse (Fisher & Baum, 2010). Adverse experiences in childhood are also associated with worse mental health in later life. Circumstances in childhood such as poor living conditions; experiences of physical or sexual abuse; being witness to domestic violence; and emotional abuse are all associated with poor mental health outcomes and diagnoses in adulthood (Edwards, Holden, Felitti, & Anda, 2003). A life-course perspective emphasizes that stressors, such as those experienced in challenging living conditions, accumulate. These stressors affect mental health at different life stages and social inequalities create an accumulation of stressors across the life course, leading to higher risk of distress and potential for diagnosis of mental disorder (Allen, Balfour, Bell & Marmot, 2014).

Those that do work using the SDOH approach tend to use epidemiological measures to understand physical and mental health (ie: rates of illness or disorder). When exploring mental health and distress however, it is essential not to look solely at increased rates of disorder, but to look at the context and circumstances in which distress or poor mental health occurs. There is clear benefit in understanding the social determinants impacting both physical and mental health.

Identifying rates of illness and disorder and equating physical and mental health however, has the ability to perpetuate reductionist understandings of mental health.

As noted above, mainstream understandings of mental health have framed it to be a form of disease or illness equal to physical health. Specifically, the critical mental health literature indicates that analogies drawn to disease are not always helpful and are inadequate for understanding mental health (Burstow, 2013; McGruder, 2002; Malla et al., 2015). In the SDOH approach, the understanding of mental health needs to account for people's experiences of distress. Reporting only rates of 'mental illness' among different groups as with rates of physical illness assumes that distress or 'mental illness' are analogous to physical illness and discounts the lived experiences that may be contributing to distress. It is particularly important to ensure that labels (such as psychiatric diagnoses) and rates of mental disorder, particularly among those in impoverished living conditions, are not decontextualized and pathologized. Mills (2015), describes this decontextualization as the 'psychiatrization of poverty,' where labels and diagnoses are not questioned, and social, political and economic circumstances that create distress are medicalized. Furthermore, in understanding higher rates of mental disorder among marginalized groups including women or racialized communities, the disorder is often analysed at the level of the individual, and separated from the structures and conditions creating distress. This type of focus insulates governments from responsibility and frees policymakers from addressing poverty, structural racism, sexism, heterosexism, and other forms of discrimination (Mills, 2015) such as misogyny.

...while poverty may lead to psychological distress, correcting only the psychological issues will not necessarily correct the conditions of poverty that lead to the distress in the first place or the political-economic forces that produce and sustain poverty and economic marginalization. Thus, not only does such psychiatrization overlook the conditions of inequality and poverty that may lead to distress initially, it may actually allow such conditions to persist or worsen.

(Mills, 2015, p. 218)

In my SDOH approach, I include determinants such as income, living in poverty (Allen et al., 2014; Fisher & Baum, 2010; Raphael 2009b), material disadvantage (Allen et al., 2014), employment (Allen et al., 2014; Fisher & Baum, 2010; Raphael 2009b), working conditions (Allen et al., 2014; Fisher & Baum, 2010; Patel, 2010; Raphael 2009b), educational attainment

(Allen et al., 2014; Fisher & Baum, 2010; Patel, 2010; Raphael 2009b), food security (Mills, 2015; Raphael, 2009b), housing (Mills, 2015; Raphael, 2009b), health care services (Raphael, 2009b), social isolation or lacking social support (Allen et al., 2014; Fisher & Baum, 2010; Raphael, 2009b), racialization (Mills, 2015; McGruder, 2002; Morrow & Weisser, 2012), immigration (Castañeda et al., 2015), Aboriginal status (Raphael, 2009b), gender (Allen et al., 2014; Patel, 2010; Raphael, 2009b), dis/ability (Raphael, 2009) and sexuality (Logie, 2012). It is not these determinants alone that create good or bad health, but the experiences associated with the determinants resulting in acute and chronic stress in certain living and working conditions as well as stress resulting from experiences of discrimination. The stress associated with certain determinants along with particular experiences of discrimination in turn affect individuals' physical and mental health and wellbeing. For example, sexuality as a determinant of mental health may mean that a person who is lesbian, gay, bisexual, trans, queer, questioning, intersex, or two-spirited (LGBTQI2S) may experience additional stress (both acute and chronic) in relation to experiences of discrimination such as when seeking employment, housing, accessing appropriate and informed health and mental health services or experience distress through social isolation and lacking social support (Logie, 2012).

In this dissertation in the study of mental health I use a SDOH framework as one that understands living and working conditions as determinants of both physical and mental health, but also one that understands mental health and distress in context. This understanding of mental health is informed by the critical mental health literatures (Bracken et al., 2012; Burstow, 2013; McGruder, 2002; Malla et al., 2015; Mills, 2015), moves the focus beyond rates of 'mental illness' among different groups (Hankivsky & Christoffersen, 2008), does not render 'mental illness' and 'physical illness' as synonymous (Malla et al., 2015), and employs a broader understanding of "health" that includes mental health as one aspect. This approach considers context and resultant policy implications for example, beyond mental health policy, social policy must address not only issues of inadequate income, un/underemployment, and lack of safe and affordable housing, but must also work to address structural issues of systemic racism, sexism, heterosexism and other forms of xenophobia, which lead to systemic discrimination and profound stressors, with negative impacts on individuals' mental health and wellbeing. Ultimately, a SDOH approach provokes questions, including to what extent is mental distress a reasonable response to unreasonable circumstances?

2.2.3 Equity in mental health

Feminist political economy and a SDOH approach inform how mental health equity is understood in this dissertation, which includes what is required to create conditions conducive to good mental health as well as access to appropriate supports for those in distress. This section outlines my understanding of equity in mental health and the role of neoliberalism in mental health equity and inequity. This understanding of equity in mental health moves beyond a biomedical, reductionist understanding of mental health, to one that is informed by the inclusion of individuals' daily lived experiences set within the contexts of social, political and economic circumstances, many of which lie outside of individuals' control.

In this dissertation, mental health equity will refer to equity within good living and working conditions for all individuals, as well as equitable access to mental health services for those in distress. Services for those in distress include not just medical, psychiatric and psychological/counselling services, but also social support services and programming, which support good mental health. Factors impacting mental health inequities are considered when speaking to the factors leading to distress and resulting in activation of paramedic services for mental health needs. Furthermore, exploring services and means of managing or addressing mental health calls in the prehospital setting will be done with a lens on the factors contributing to equity in mental health and wellbeing, as well as equitable accessibility of services.

Conditions for equitable mental health must address social conditions across the life course, which may contribute to positive mental health (Allen et al., 2014; Fernando, 2010; Fisher & Baum, 2010), along with appropriately accessible services for those struggling with their mental health (Fisher & Baum, 2010). Equity in mental health must speak to the ambiguity in diagnoses of 'mental illness,' particularly in relation to race and culture. Fernando (2010) states that much of western psychology/psychiatry is based in individualistic understandings of mental health, which are not necessarily applicable or useful cross-culturally, especially in more collectivist cultures. For those in distress who may have emigrated from more collectivist cultures, this may result in inappropriate or insufficient mental health support services, an inadequate understanding of coping styles and support systems, and western diagnoses of 'mental illness' where such diagnoses would not have been applied in other cultures and settings (ibid).

Fernando (2010) also speaks specifically to the histories of sexism, racism, homophobia and ethnocentrism in psychology and psychiatry, which while historically were more explicit, create issues embedded in many mental health systems. He identifies histories, including the previous presence of homosexuality as a psychiatric disorder in the Diagnostic and Statistical Manual (DSM), as well as ‘Drapetomania,’ the disease that would drive black slaves to run away from service as evidence of this past. There is now substantial literature identifying the ways in which psychiatry has pathologized certain groups, such as women, racialized people, and those living in poverty (Fernando, 2010; McGruder, 2002; Metz, 2009; Mills, 2015; Morrow & Weisser, 2012; Ussher, 1991; Ussher, 2011). Examples include higher rates of diagnosed mental illness among black people (Adebimpe 1981a; Adebimpe 1981b; Bell & Metha 1980; Coleman & Baker 1994; McGruder, 2002; Morrow & Weisser, 2012), for example, schizophrenia in black men (Coleman & Baker, 1994; Jones & Gray 1986; Morrow & Weisser, 2012) or the pathologizing of women’s experiences such as the post-partum period and menopause (Morrow & Weisser, 2012; Ussher 1991; Ussher 2011). Such examples draw attention to ambiguity in diagnoses of ‘mental illness,’ a high level of subjectivity in diagnosis and the discounting of contextual, life experience.

Diagnoses of ‘disorder’ and ‘illness’ may discount individuals’ life context and circumstances beyond their control, specifically when discounting the effects of trauma resultant from persistent, systemic racism (Fernando, 2010). Disproportionate rates of diagnoses among certain groups, as well as historically identified ‘disorders’ such as homosexuality and ‘drapetomania,’ call into question the subjectivity of what is understood as good or ‘normal’ mental health or as mental ‘illness.’ In considering the trauma of lived experiences such as racism, sexism and homophobia it draws attention to what might be ‘mental illness’ or abnormal mental health versus normal responses to exceptionally challenging and problematic conditions and experiences. Equitable conditions for good mental health as well as equitable access and appropriateness of mental health care services must account for such context and history in understanding what may be driving distress, as well as what is labeled ‘disorder’ or ‘illness.’ Working toward equitable conditions conducive to good mental health requires questioning labels of mental ‘illness’ as well as the impact that these labels have on individuals’ lives, experiences of discrimination, as well as on their access to mental health supports and services when experiencing mental distress.

In order to work toward equitable conditions conducive to good mental health, it is necessary then to address the conditions impacting individuals' mental health. "People are made vulnerable to mental ill-health by deep-rooted poverty, social inequality, and discrimination" (Allen et al., 2014, p. 402). Money, power and resources significantly shape the determinants of mental health (Shim et al., 2014) and there is unequal distribution of mental distress among individuals who are socially and economically disadvantaged (Allen et al., 2014; Patel, 2010). This draws attention to the role of policy and politics in addressing mental health (Shim et al., 2014). As such, working toward equity in mental health, means working toward equitable living and working conditions conducive to good mental health.

Along with the conditions contributing to individuals' good mental health, it is necessary also to address the care, supports and accessibility for individuals experiencing distress. As in the case of health, where Sherwin (1996) argues that resource allocation is to include "all of the conditions that contribute to good health," (p.201) it is relevant to include here all of the conditions that contribute to good mental health – including appropriate living and working conditions as well as mental health services. Care and equitable allocation of mental health resources includes acute care, crisis services as well as social care - - defined as "the activities and relations involved in meeting the physical and emotional requirements of dependent adults and children, and the normative, economic and social frameworks within which these are assigned and carried out" (Daly & Lewis, 2000, p.285). As such, mental health services in the prehospital setting will be explored in relation to actual access to mental health services and appropriateness of mental health supports, as well as accounting for the range of care and social supports existing for those in the community.

2.2.4 Neoliberalism as a context for equity in mental health

In exploring mental health care supports and services in Ontario and Canada, it is necessary to consider where responsibility for provision of these services lies as this impacts not only accessibility to mental health services but the types of services available. Individual responsibility is a core tenet of neoliberal ideology, including responsibility of an individual for their own physical and mental health. Teghtsoonian (2009) identifies neoliberal ideology to be embedded in much mental health discourse, highlighting that responsibility for individuals for self-care and placing responsibility on families, communities and workplaces to care for mental

health and wellbeing. This framing shifts responsibility away from government and social structures, depoliticizing mental health and care. Feminist political economists have identified the need to reconceptualize care from something in the private domain to the public, without which social and economic inequalities are reinforced (Daly, 2013; Daly & Lewis, 2000). Care is to be considered an integral part of living in a welfare state (Daly, 2013), and as such equitable mental health care arises from government and policy makers, working to address social and economic inequalities, which contribute to poor mental health.

Neoliberal ideologies are reflected in mental health policy discourses, which support “reducing levels of government spending and taxation by redirecting our gaze *away* from public sources of funding and support for programs and services and *toward* private resources located in families, communities and workplaces” (Teghtsoonian, 2009, p.32). Additionally, Teghtsoonian (2009) identifies that policy directions leading to higher rates of job insecurity, intensified work, and reduced public services have the potential to contribute to poverty, stress, fatigue and lack of control over one’s environment – factors understood to be associated with depression.

Esposito & Perez (2014) note that the tendency to view ‘mental illness’ as a problem located within the individual is supported with neoliberal ideologies and prevailing neoliberal ideologies shape what is understood to be ‘normal’ behaviour and ‘normal’ mental health. Furthermore, thoughts and behaviours that stray from this ideal are then to be treated, meaning that good mental health or sanity can be bought, sold and profited from (ibid). They provide an example of anxiety and depression, where they are “treated as self-contained ailments that can be resolved individually through pharmaceutical drugs, as opposed to being by-products of a market society, where the emphasis on profit/personal gain and competition erodes social bonds and promotes alienation” (p.416).

Neoliberal policy and ideologies thus impact the conditions and determinants that impact mental health, as well as both the way we understand good mental health and ‘normalcy’ and the way we treat individuals in order for them to achieve this type of good mental health. When working toward equitable conditions for good mental health and equitable access to appropriate supports and services for mental distress, the role of dominant neoliberal ideologies must be acknowledged and challenged.

2.3 Applying the methodology

A critical analysis of mental health calls in the prehospital setting has been seldom applied in the academic literature (Ford-Jones & Chaufan, 2017), particularly with feminist political economy and SDOH approaches. Discussions of paramedic calls have lacked focus on the context and factors affecting distress that result in these calls, and have focused more on quantitative analyses of rates of mental health calls (Clark et al., 1999; Larkin, Claassen, Pelletier & Camargo, 2006), protocols to address them (Larkin et al., 2006), and are based largely in a biomedical or individualized focus on mental illness (Clark et al., 1999; Larkin et al., 2006). Here I discuss how I have applied feminist political economy and SDOH approaches together to work toward a more contextualized understanding of the issue and the relevance of this framework in studying mental health care in paramedicine.

In this dissertation I use a SDOH framework informed by the critical mental health literature along with a feminist political economy approach. The critical mental health literature enhances the understanding of mental health away from epidemiological, reductionist understandings of mental health to a contextualized understanding of mental health and causes for distress. While this approach helps us to understand mental health, feminist political economy helps us to understand the person receiving and providing care.

Feminist political economy and a SDOH approach were integral to all aspects of this research, informing the choice of a case study, the research questions, choice of methods, observation and data collection process as well as analysis. I see these theories fitting together with feminist political economy contributing the lens that the whole is greater than the parts (Bezanson & Luxton, 2006) in which distress is not simply mental illness, but made up of many parts including social, political, economic and cultural contexts. Specifically, feminist political economy highlights the following: the study of gender, race, class, sexuality, age, ability and systemic forms of discrimination; the role of lived experiences; social relations; and the processes of social reproduction. I see the SDOH as illuminating these contexts through identification of the determinants or conditions that are known to impact mental health and create distress.

Figure 2.1 Methodology: Feminist political economy and the SDOH

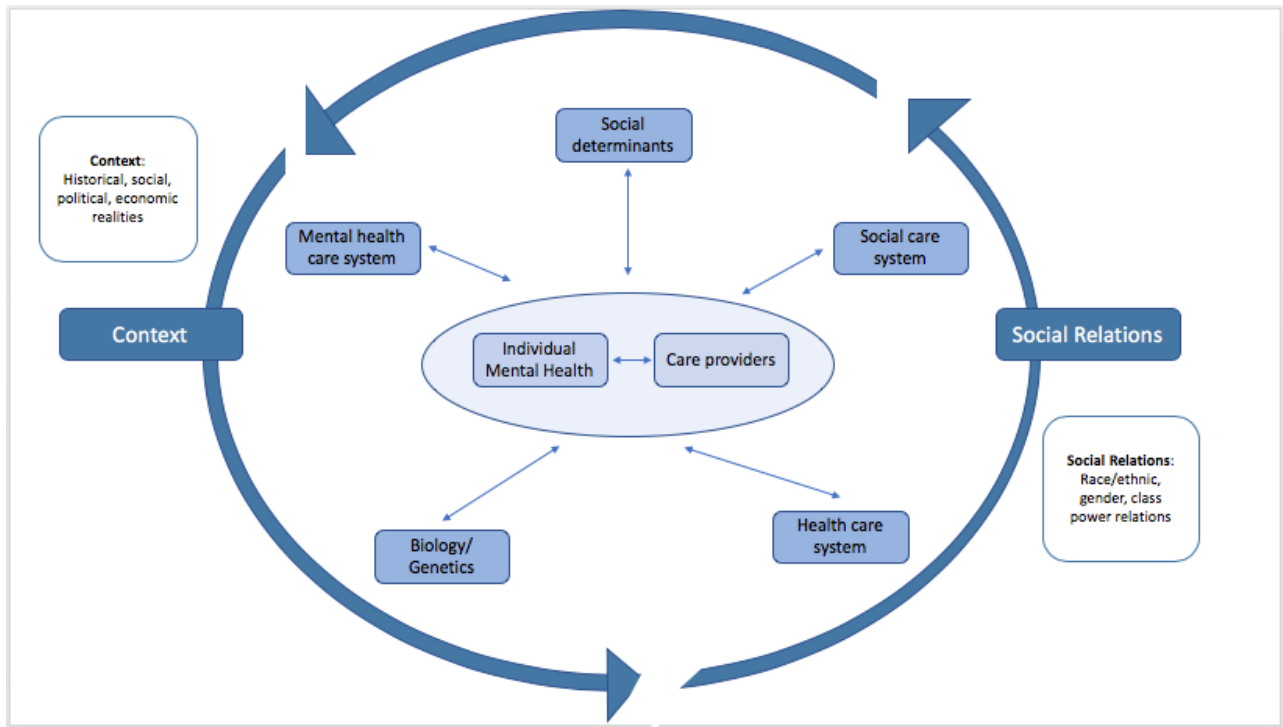


Figure 2.1 illustrates the way I see feminist political economy and the SDOH approaches fitting together to understand individual mental health and care providers. Context is “the circumstances that form the setting for an event, statement, or idea, and in terms of which it can be fully understood” (Oxford Dictionaries, 2019). Here I refer to context as the historical, social, political and economic realities, for example a neoliberal context may be one such context. Social relations, which are also impacted by context, include race/ethnic, gender, class and power relations. By social determinants, I refer to the circumstances in which people live and work, which impact both care providers and care recipients. The physical health, mental health and social care systems, as well as the conditions/determinants impact individual care providers as well as individuals in distress or requiring care. Biology and genetics also impact individuals’ distress and care needs. None of these relationships are unidirectional, and individual choices of both care providers and recipients are constrained and impacted by these other elements. Context and social relations are related and impact all of these relationships.

2.3.1 The relevance of this methodology for mental health care in paramedicine

This methodology guides the analysis from the development of the research question through to the research design and analysis. Feminist political economy led me to explore the conditions of work and care, the ways in which care work are shifted in neoliberal policy contexts, the gendered nature of work and the value of studying individuals' everyday lived experiences. The SDOH led me to explore the factors impacting distress as well as the extent to which these determinants are addressed in care. This methodology guided the questions I asked as well as the themes I looked for in my data.

Feminist political economy analyses have been conducted on health services and care work, but less frequently on mental health care (Haley, 2017). Along with the SDOH framework, these theories offer a means of gaining insights into some of the factors driving distress and potentially driving increasing rates of mental health calls. Through use of inclusive definitions of 'mental health' and 'psychosocial' calls, the study explores the range of factors that may be contributing to distress for those receiving paramedic services, as well as some of the less acute concerns, potentially informing areas for prevention. Importantly, when exploring the relationship between paramedics as care providers, and patients with mental health and psychosocial concerns as care recipients, a feminist political economy approach invites exploration not simply of what care is provided and whether it is sufficient, but the conditions in which care is carried out and received, and existent constraints and structures impacting this relationship. Through this approach, the mental health needs of care recipients and the mental health needs of paramedics as care providers are explored. Application of this approach offers the possibility of informing policy at the level of care providers in paramedic services as well as mental health policy and systems and broader social and health policy because it incorporates the context and factors leading to these calls and distress for individuals, as well as the processes involved in managing these calls at systems levels. This SDOH framework highlights the need for policy action at the level of the determinants of mental health as factors contributing to distress or determinants that may contribute to good mental health by offering a framework for determining what conditions may be conducive to good mental health as well as what may constitute good mental health supports and services. In combination, the feminist political economy approach and the SDOH draw attention to the conditions and contexts which impact people's mental health.

Specifically, with regard to care work and emergency services, this dissertation expands on previous discussion of care work and emergency services along with the gendered nature of work (Braedley, 2009, 2015). In Braedley's work on fire fighters (2009, 2015), she draws attention to shifts in care work, and traditional care roles as a result of neoliberal policy shifts and restructuring. She notes that "The relatively sudden rise in demand for emergency medical response can best be understood in the context of these changes to Canadian social welfare that began in the 1980s but escalated sharply in the 1990s, re-structuring the care economy" (Braedley, 2015, p.271). Specifically, she documents the care work provided by firefighters despite their traditionally 'masculine' and non-health care role. She identifies care gaps created by neoliberalism and the changes to how and by whom this work has been taken up. My dissertation extends this discussion on emergency service workers from typically 'masculine' professions completing traditionally 'feminine' types of care work. In this case it is paramedics increasingly providing mental health and psychosocial care for those in distress, for an extended period, as the primary care provider on emergency medical calls. This builds on previous emergency care work discussions and speaks to the gendered nature of paramedicine work, social care and the role of neoliberal policy and ideologies shaping these trends and practices.

Paramedicine in the academic literature addresses transitions in care; paramedic clinical decision making for alternate care destinations other than the ED (Masroor, 2016; Munjal et al., 2016; O'Hara et al., 2014); general patient care handoff to ED staff (Manser et al., 2010); and transitions in care for older adults from ED to home (Lau et al., 2018; Mi et al., 2018). Outside of paramedicine, literature exists around transitions in care in relation to the ED (Beach, Croskerry & Shapiro, 2003; Behara et al., 2005; Cheung et al., 2010); and mental health concerns from the ED (Nicks & Manthey, 2012). The literature about transitions in care and the role of paramedics in relation to mental health calls focuses on safety and feasibility of alternate transport destinations and protocols for those with mental health concerns (Cheney, 2008; Davis & Thompson, 2002). This dissertation extends this literature. It includes a qualitative analysis of the factors relevant for transitions in care for those in distress between home, paramedic services and the ED, as well as the outcomes of these transitions in care paramedics address with frequent users of the system. This qualitative analysis also offers opportunity for exploration of paramedics' role in mental health care, an area previously ignored in the literature (Ford-Jones & Chaufan, 2017; Prener & Lincoln, 2015).

2.4 Researcher reflexivity in research design

In this section, I discuss the importance of researcher reflexivity in the research process and identify my position in relation to this research. Feminist political economists cite how important reflexivity is for a researcher, and the importance of situating oneself in the research context (Smith, 1989). Bolam, Gleeson & Murphey (2003) define reflexivity broadly as “the active process of reflection that researchers using qualitative methods go through so as to document how the research process in general, and often themselves in particular, construct the object of research” (p. 2). In the case of my research, it was necessary for me to give thought to both how I had come to the research questions and the field, and the ways in which I see the issues.

England (1994) describes reflexivity as “self-critical sympathetic introspection and the self-conscious *analytical* scrutiny of the self as researcher” (p. 82). With such self-conscious, analytical introspection, it was not possible for me to ignore how I came to the research subject itself and the fieldwork. I was drawn to this area of study through my work as a paramedic in Ontario. I completed a two-year college paramedicine diploma and have worked in the field for eight years after that. Through my training as a student both in the classroom and in the field, through my ongoing work on the road as a paramedic and as a part-time educator in the paramedic college program setting, I came to this research with a number of insights into the field, but also a number of assumptions and biases. It was necessary to acknowledge that I came to the field with great familiarity with the nature of the work, the work setting and experiences paramedics face on the day to day.

With this in mind, I reflect on what brought me to this field of research. I came to it through seeing an abundance of calls pertaining to mental health both as a student and working paramedic, in different regions. The context and complexities in living conditions and personal traumas and histories observed on these calls drove my interest in better understanding the circumstances leading to distress, and wondering about how it extended beyond biological roots in the individual, and were impacted by a multitude of circumstances. I wondered if in fact any person living in many of these circumstances would be experiencing distress, as a fairly reasonable response, to extraordinary circumstances? Additionally, the limited attention and focus that these calls appeared to receive in my experience with paramedicine, drove my desire to understand why? What better supports could these calls receive? As I continued my work as

a paramedic separate from, but alongside my research, I would consider these questions when attending to calls, refueling my sense that greater attention needs to be placed in this area of paramedicine.

Despite my own experience in the field, the perspectives of other paramedics with different experiences and realities and from different paramedic services in Ontario revealed similar experiences, while at the same time shedding light on particular circumstances in different regions and paramedic services in the province. This also guided my intent to carry out ethnographic research in this field, exploring and wanting to capture the landscape of mental health and related calls in paramedic services in Ontario beyond my own experiences.

Arber (2006) discusses her experience conducting ethnographic research as a health practitioner, and the feeling of both being an ‘insider’ as well as an ‘outsider’ at times. She discusses that as a nurse, her familiarity with the medical world, language and culture made her feel at home in that world. This is part of the ‘insider’ experience, whereas when observing within a department in which she was not familiar and had not worked, she was more of an ‘outsider.’ Similarly, my experience of feeling like an ‘insider’ was present in my familiarity with the language, the equipment, the general paramedicine culture and many aspects of the work. This ‘insider’ feeling was particularly strong when the management with whom I sought approval to conduct the research assured me that this was a much easier process because I am a paramedic, or when the paramedics with whom I observed said they felt relieved not have to ‘babysit’ me. I did however feel like an ‘outsider’ on many occasions as I had never worked in the services in which I observed, I was not familiar with their stations, or the nuances to their ways of working, as well as the towns and cities within which they worked.

Smith (1990) discusses the role of the expert in inquiry. “For each of us is an expert practitioner of our everyday world, knowledgeable in the most intimate ways of how it is put together and of its routine daily accomplishment. It is the individual's working knowledge of her everyday world that provides the beginning of the inquiry.” (Smith, 1990, p.154). Indeed, paramedicine work is often a part of my ‘everyday world’ and I have significant familiarity with the field. It was evident at many points however, that I was not familiar with certain aspects of these paramedics’ ‘everyday,’ and it was their expertise that I hoped to explore. Feminist political economy highlights the importance of everyday lived experiences and as Smith (1990) notes, that participants are experts in their own ‘everyday.’ Using this approach, I situated the

participants in the study - - frontline paramedics, educators, management and Base Hospital managers/physicians - - as the experts in the field. It was their lived experiences that they shared with me that would help to illuminate this issue. While I had expertise in my own everyday experiences as a paramedic, it was important to document a range of paramedic and related workers' experiences.

2.5 Conclusion

This chapter addresses the methodology guiding the dissertation research, a methodology not previously applied in the area of paramedicine and mental health calls. The ways in which the methodological framework is suitable for exploring the subject matter is discussed as it relates to understanding mental health, mental health care and mental health equity. Feminist political economy highlights what tensions exist for paramedicine and mental health needs, in particular between structure and peoples' agency, both for those providing care as well as those receiving care. Furthermore, it draws attention to the relevance of daily, lived experiences of care recipients as well as the working conditions and structures impacting care provided by paramedics. In conjunction with a SDOH approach, feminist political economy offers a framework to investigate the conditions or determinants contributing to distress and mental health calls to paramedic services. This lens offers potential insights to both practice at the level of paramedicine as well as to mental health and social policy. The research methods employed, guided by this methodological framework will be explored in the following chapter.

Chapter 3: Research Methods

3.0 Introduction

As outlined in Chapter 1, the literature surrounding mental health and psychosocial calls in the paramedic services setting is extremely limited. While there is some literature on mental health emergencies in other emergency services settings, specifically policing (Lamb, Weinberger & DeCuir, 2002; Shapiro et al., 2015; Steadman, Deane, Borum & Morrissey, 2000; Teller, Munetz, Gil & Ritter, 2006; Watson & Fulambarker, 2012) and the emergency department (ED) (Clarke, Dusome & Hughes, 2007; Kerrison & Chapman, 2007; Larkin et al., 2005; Larkin et al., 2006; Newton et al., 2010; Digel Vandyk, Young, MacPhee & Gillis, 2018), this literature does not capture the specific experience of mental health calls in the prehospital setting by paramedic services. The grey literature and limited academic attention on paramedicine indicates that these calls are occurring at a potentially increasing rate and volume (Brady, 2012; Campbell & Rasmussen, 2012; CBC News, 2012; CTV London, 2015; Ford-Jones & Chaufan, 2017; Prener & Lincoln, 2015; Roberts & Henderson, 2009; Vandonk, 2014). Additionally, the Ontario Ministry of Health and Long Term Care (MOHLTC) identifies that over 2000 Ontarians made twelve or more ambulance trips to hospital in 2016/17 with the most common diagnoses for the user related to mental health and addictions (MOHLTC, 2018g). Despite this identified substantial and increasing call volume, there is a lack of understanding of the nature of the calls, the conditions in which they occur, the ways in which they are managed and what guides this management. Furthermore, there is a gap in the literature with regard to the ways in which these services address the SDOH. The paucity of data and theorizing informed this dissertation's ethnographic research design: a single case study of mental health and psychosocial paramedicine care in Ontario, Canada with 3 most different subunit sites (Yin, 2014). The field research was conducted between September 2017 and October 2018.

A case study is a suitable research approach to consider when the research question being asked about a current event or situation, is a 'how' or 'why' question, and aims to understand the contextual conditions in which a particular event or situation occurs (Yin, 2014). The research question in this study aims to understand *how* mental health and psychosocial care is currently managed in the paramedic services setting in Ontario, *how* this practice is guided and *how* these services address the SDOH. Additionally, guided by a feminist political economy approach, this study aims to understand the contexts in which the social, political and

economic conditions and everyday lived experiences affect mental health, as well as the conditions affecting the occurrence and management of these calls in the prehospital setting. The SDOH framework aims to further understand the determinants of mental health existent in these contexts, impacting mental health needs and distress, and potentially mental health and psychosocial calls to paramedic services.

This chapter discusses the case study research design; ethical review and considerations; sampling criteria; descriptions of the anonymous sites; recruitment processes for engaging with paramedic services; data collection methods (i.e. key informant interviews, ethnographic observations, and document analyses); and data analysis. Specific challenges and findings related to research methods throughout the research process are addressed in the final sections.

3.1 Case study research design

This dissertation researched several aspects of paramedic care: the content and conditions of mental health and psychosocial calls; the training and practice guidelines shaping knowledge; how guidelines and knowledge are practiced by paramedics; the working conditions in which paramedic care is performed, as well as exploring paramedics' experiences with the living and working conditions of the people they care for. In this section I outline the strengths and relevance of a case study design for this research.

A case study approach was employed to explore the phenomena within a real-life context (Yin, 1999), and to incorporate a variety of data sources (Baxter & Jack, 2008; Yin, 2014). The inclusion of multiple sources of evidence as well as inclusion of multiple perspectives in the field allowed for triangulation of data aiming to increase the construct validity, and validate findings across multiple sources (Yin, 2014) and perspectives (Carter, Bryant-Lukosius, DiCenso, Blythe & Neville, 2014). This variety of sources “ensures that the issue is not explored through one lens, but rather a variety of lenses which allows for multiple facets of the phenomenon to be revealed and understood” (Baxter & Jack, 2008, p.544). Case study research is further beneficial in its flexibility where there is clarity lacking in the boundary between a phenomenon and its context (Yin, 1999). In this case, this flexibility was beneficial in order to be able to explore the conditions effecting mental health calls.

Despite the flexibility and exploratory capacity of the case study method, a clear framework for operationalizing the study was necessary (Yin, 1999) as well as clarity in defining

and placing boundaries on the case - whether by time and place, activity, definition and or context - in order to prevent being overwhelmed by data (Baxter & Jack, 2008). It was necessary to return frequently to the research questions and propositions guiding the study (Baxter & Jack, 2008 and Yin, 2014) in order to place limitations on the scope of the study.

The research design is a single case study of mental health and psychosocial paramedicine care in Ontario using 3 comparative case sub-units (3 separate paramedic services referred to as sites) selected on the basis of difference: Site 1: Primarily urban with some suburban and rural communities with program level engagement for mental health calls; Site 2: Rural, with no specific program level engagement with the issue of mental health calls or specific programming; Site 3: Rural and suburban with some limited first response resources for mental health calls. The parameters bounding these sites will be explained below in the ‘Sampling criteria’ section, drawing on health geography and a SDOH approach.

3.2 Study Flow

3.2.1 Ethics

Ethics approval was obtained from York University’s Office of Research Ethics. The Tri-council Policy Statement (TCPS2 – Tutorial Course on Research Ethics) tutorial was completed as part of the approval process. Informed written consent was obtained from participants for both interviews and observations (Appendix I & II). Consent for inclusion as a sub-unit was obtained from the paramedic service’s management. I requested the service’s permission to allow their paramedics’ participation in interviews and to allow me to perform shift observations. All individual paramedics also provided their individual and voluntary consent. Other key informant interviews conducted outside of the three sites of observation with individual paramedics, educators, and Base Hospital physicians or management were contacted by requesting their participation in an interview about paramedics and mental health calls. Each participant provided their individual and voluntary consent.

The focus of the research is neither patients nor paramedics as individuals, but on the conditions within which paramedics work and those in which patients receive care. For observations in paramedic services, voluntary informed consent was obtained from any paramedic (or crew) with whom I was shadowing to conduct work observations. As with other ethnographic research, the process of obtaining consent for observation research was not a single

event but an ongoing process (Bailey, 2007; Murphy & Dingwall 2007; Pope, 2005).

In the emergency prehospital setting many individuals enter into the field of observation. (Roberts, Henderson, Willis & Muir-Cochrane, 2013). I established an observation protocol approved by the ethics committee. For an observation shift, I wore a name badge stating my name and my role as a doctoral candidate with York University. I introduced myself when possible and/or the paramedic crew indicated my observer status. If a patient or family member indicated that they did not wish to have me present, or if the paramedic crew indicated that I ought not to be present for a given call, the protocol indicated I would return to the ambulance or not exit the ambulance. This situation did not arise during my observation shifts. In order to ensure confidentiality for the recipients of care on calls, no names, dates of birth or addresses from calls were recorded in field notes or referred to in the analysis in accordance with the *Personal Health Information Protection Act* (PHIPA) (2004). With respect to the anonymity of the paramedics providing care, as well as the paramedic services being observed, real names of paramedics and specific paramedic services are changed in this dissertation and in future publications.

The data are stored in a secure home office, accessible only by the principle investigator. Raw data are accessible only to the principle investigator and committee members and will be destroyed in the year 2053. The data will be retained to enable future research and publications.

3.2.2 Sampling criteria

In this section I outline the factors considered in determining the paramedic services with which to engage. Primarily, I did not engage with the paramedic service where I am employed, or any of the immediately surrounding services in order to minimize interaction with current colleagues, as well as former students. I considered attempting to engage only with paramedic services participating in a mental health call specific pilot project or other program to gain insight into services specifically engaged with addressing mental health. However, I also wanted an understanding of the experiences of those in services not specifically engaged with mental health projects. Additionally, I wanted to compare an urban with a rural context to explore the potentially different experiences in these communities including what factors might be contributing to distress or mental health needs as well as different experiences of mental health care and access to supports and services. Milligan (2005) identifies a failure on the part of policy

makers to appropriately identify the specific needs for those with mental health needs in rural communities, versus those in urban communities who typically receive greater attention. Logistically, I also needed to ensure that I could travel by car to the sites within a reasonable commuting distance from my lodgings. The selection of Ontario as the case for study was one of convenience, based on my location and ability to access multiple paramedic services in person. The attributes of Ontario as a case will be explored below, with attention to the way this case may be understood in comparison to other provinces, and regions.

Space and place make up important elements of the context when looking at mental health needs and care. Space is defined as more abstract than place with “areas and volumes” (Cresswell, 2004, p.133) and has been described as “a realm without meaning” (Cresswell, 2004, p.134). Place is “a meaningful location” (Cresswell, 2004 p.132) and “an area of the world as a rich and complicated interplay of people and the environment” (Cresswell, 2004, p.136). Therefore, a space which has meaning attached to it becomes a place. Within health geography, “places matter” with regard to health, disease and health care (Kearns & Moon, 2002, p.610), and place matters for issues of mental health and mental health care (Milligan, 2005; Parr & Philo, 2003; Parr, Philo & Burns, 2004). As such, the sampling strategy of paramedic services required careful consideration. “Care and care relationships are located in, shaped by, and shape particular spaces and places that stretch from the local to the global” (Milligan & Wiles, 2010, p.736). Places matter with regard to the living and working conditions of individuals in communities and the extent to which they may experience distress or good mental health, but also the ways in which care is experienced, provided and available. There are differences in spaces and places that are necessary to capture in trying to better understand the circumstances of mental health calls in paramedicine in Ontario, the locations in which care is provided, as well as the relationships of care.

Health geographers have highlighted the relevance of space and place in care provision by looking at the ‘landscapes of care,’ which they note “can encompass the institutional, the domestic, the familial, the community, the public, the voluntary and the private as well as transitions within and between them” (Milligan & Wiles, 2010, p.738). Different spaces and locations are not simply different geographical areas, but the geographies and different locations of care encompass different experiences and realities within communities with regard to living

experiences as well as what supports, services and resources are available to people day to day, or for mental health needs in particular.

Milligan (2005) states that the study of mental health and distress in rural settings has been largely quantitative and concerned with clinical or biological models with far less attention to social or environmental factors. She notes that there must necessarily be differences in provision of mental health care between dense, urban cities and rural communities, yet this is not always accounted for in the ways in which local services are provided. Care is configured in different ways due to economic, political and social geographies of different locations (Parr & Philo, 2003) and feminists draw attention to questions of who cares (Milligan & Wiles, 2010), bringing our focus to differences that may exist in who provides care and what kind of care is provided in different locations.

A single case with embedded units was used as I wanted to explore the experiences of more than one paramedic service, to increase generalizability of findings about mental health and psychosocial paramedicine calls. I selected the overarching case of Ontario, in part, because Ontario is where I live and what I know best. Selecting the province to bound the case meant that there is one set of standards that are shared across sites, but variation within and between the sites in terms of the geography and their community composition (Baxter & Jack, 2008, p.550). At different points of the analyses and among different themes, the ‘within,’ ‘between’ and ‘across’ subunit analyses serve to illuminate different aspects of the case. Baxter & Jack (2008) highlight the importance of also returning to the broader case, and ensuring that the focus is not solely on analysis within subunits.

It was necessary to establish clear boundaries for inclusion or exclusion criteria in sample selection, which indicate the breadth and depth of the case (Baxter & Jack, 2008). While tempting to explore many paramedic services across Ontario in detail, it was not feasible. In order to capture a broader perspective of the circumstances in Ontario, I conducted interviews with key informants in the field of paramedicine from across Ontario, but did not conduct observation in all services.

In discussing sampling in qualitative research among a variety of studies, Curtis et al., (2000) identify that “a simple ‘blueprint’ for qualitative sampling could not be imagined, since each study requires a specific strategy” (p.1012). They discuss the six criteria for sampling selection put forward by Miles & Huberman (1994): 1) the strategy should be relevant to the

conceptual framework and research questions; 2) the sample should generate rich data about the subject of study; 3) the sample should increase the ‘generalizability’ of findings; 4) the sample should result in believable ‘true to real life’ descriptions or explanations; 5) the strategy should be ethical; 6) the strategy should be feasible. Curtis et al. (2000) state in their findings, that all six criteria could not consistently be applied across different studies, however different elements of these guidelines prove useful for guiding sampling. As such, a rigid set of guidelines for sampling was not employed, however certain factors and considerations in sampling were relevant and provided useful guidelines in my approach to sampling. In this case, it was necessary to determine selection criteria that would allow for representation from across Ontario for generalizability rather than in only one region of Ontario, and limited services for observation for the sake of feasibility as a solo researcher on this project.

I used purposive sampling, which involves sampling a particular case based on the research objectives (Creswell, 2009), as outlined above. I expected to find gaps in mental health care resources and training in paramedic services across Ontario, such as differences in the community needs and resources between rural and urban services. Additionally, in purposively sampling based on differences in mental health programming in paramedic services, I expected to find different levels of engagement with mental health care in paramedicine – greater attention to this care in the services engaged in programming, less attention to this care in those that were not. I also used snowball sampling to recruit individuals, whereby I sought out recommendations for other participants for the study (Bryman & Teevan, 2005).

In terms of engaging paramedic services in the study, I began through networking with a member of management from one paramedic service while at a conference whose service had been addressing the issues stemming from an overwhelming number of mental health calls in their service and studying potential practices. Fitting the first of my site selection criteria, a follow-up meeting to discuss this project resulted in engaging that paramedic service as a site as well as recommendations to work with other paramedic services.

3.2.2 (a) Ontario as the case for study

There is extremely limited literature on paramedicine, paramedic services organizations, and structures in paramedic services, and there is no distinct literature comparing paramedicine and paramedic services within Ontario to other provinces or even other countries. There are

certain distinctions with regard to paramedicine and paramedic training within Ontario, that may differ from other regions.

Paramedics in Ontario work under the authorization of an Ontario Base Hospital, as will be further discussed in Chapter 4. Of note here is that paramedics in Ontario are not self-regulated and not part of a ‘College of Paramedics’ for registered paramedics in Ontario (Ontario Paramedic Association, 2019). In many regions of the United States as well as Canada, paramedic services work under a delegated practice ‘medical direction’ model, where paramedics are overseen by physicians (O’Meara, Wingrove & Nolan, 2017). In Ontario paramedic acts are delegated and paramedics are overseen by physicians through a Base Hospital. Comparatively for example, paramedics in Saskatchewan and New Brunswick are self-regulated, Alberta has the Alberta College of Paramedics under a ‘delegation model,’ meaning that medical acts are still delegated by a physician, however there is movement toward self-regulation and Manitoba and Nova Scotia are seeking self-regulation (Ontario Paramedic Association, 2019). In countries such as the UK, Ireland, Australia and New Zealand, there are regulatory boards and clinical governance systems overseeing paramedic practice (O’Meara et al., 2017). Change toward college or self-regulation models have been an issue under debate in Ontario (Ontario Paramedic Association, 2019) and elsewhere, with claims that there is a lack of evidence for the effectiveness of the ‘medical direction’ model for the paramedic profession, and movement away from this as consistent with an international vision for paramedicine as an autonomous, self-regulated health profession (O’Meara et al., 2017). Furthermore, in countries such as Australia and New Zealand (Hou, Rego & Service, 2012; Munroe, O’Meara & Kenney, 2016; O’Brien, Moore, Dawson & Hartley, 2014), paramedic education and training is done at the level of a university based degree rather than at the college level such as the case of Ontario. While the debates around self-regulation and movement from college to university degrees are not the subject of this dissertation, the current structure of paramedicine in Ontario has implications for education, protocols, standards and the ways in which paramedics practice, and also the ways in which change may occur in paramedic practice.

Ontario has the largest ambulance service in Canada, with approximately 8500 paramedics (MOHLTC, 2018g). There are 57 paramedic service providers (municipal, private, hospital, First Nations and volunteer) (Figure 3.1), which serve over 440 individual municipalities and First Nations communities. Additionally, there are 22 Central Ambulance

Communication Centres (CACCs), responsible for receiving and dispatching calls to ambulance/paramedic services (MOHLTC, 2018g). The paramedicine system is jointly operated by the MOHLTC, the municipalities and Ornge (non-profit air ambulance), with up to 50% of funding received from the MOHLTC for land ambulance services (MOHLTC, 2018g sector overview). The North East and North West LHINs had the highest rates of ambulance utilization in the 2016/17 year and the Central LHIN had the greatest usage increase over the last 10 years. The rate of ambulance usage in Ontario for those aged 65+ is more than four times higher than for those under 65 and the most common diagnoses for repeat ambulance users (more than 12 trips per year) was mental health and addictions (MOHTLC, 2018g EHS sector).

In its overview of “Ambulance Attendants and Other Paramedical Occupations,” Service Canada (2015) describes a sharp increase in the population of paramedics due primarily to increased demand for ambulance services. Service Canada (2015) cites high employment rates for paramedics with higher than average salaries for technical training graduates. As of 2017, 67% of Ontario paramedics worked full-time (MOHLTC, 2018g). Figure 3.2 provides an age and sex breakdown of Ontario paramedics as of 2017 with approximately 34% female, and 66% male. The table also shows paramedic numbers by sex and level of certification (Figure 3.3): primary care paramedic (PCP), advanced care paramedic (ACP) and critical care paramedic (CCP) – designations further described in Chapter 4 (Section 4.3.2). The greatest proportion of paramedics, both male and female, are between the ages of 30-39, also with a large proportion of men between the ages of 40-54 and a much smaller number of paramedics aged 55 and over for both men and women. There is no research discussing the ethno-racial composition of paramedics in Canada, but given the sharp increase in this paramedic population, the demographics are likely shifting quickly.

Figure 3.1. Ontario Ambulance Services

| LHIN | Ambulance Service | LHIN | Ambulance Service |
|-------------------------------------|--|-------------------------|---|
| Erie St Clair | Essex-Windsor Lambton Medavie – Chatham Kent | Central | City of Toronto* York Region |
| South West | County of Bruce County of Grey County of Huron Medavie – Elgin Middlesex-London Norfolk Oneida County of Oxford Perth County | Central East | City of Kawartha Lakes County of Northumberland Durham Region City of Toronto* Peterborough Haliburton |
| Waterloo Wellington | Guelph-Wellington Waterloo | South East | County of Frontenac Hastings-Quinte Lanark County* Leeds Grenville County of Lennox and Addington |
| Hamilton Niagara Haldimand Brant | County of Brant Haldimand Halton Region* Hamilton Niagara Norfolk County Six Nations | Champlain | City of Ottawa Cornwall S.D. & G. Lanark County* United Counties of Prescott- Russell County of Renfrew |
| Central West | Dufferin City of Toronto* Peel Region* | North Simcoe Muskoka | Beausoleil First Nation Simcoe Muskoka Rama Mnjikaning |
| Mississauga Halton | Halton Region* City of Toronto* Peel Region* | North East | Algoma District Greater Sudbury Cochrane District James Bay Manitoulin-Sudbury Mattawa General Hospital Naoakamegwanning North Bay Parry Sound District of Sault Ste. Marie Sensenbrenner Hospital Temagami Timiskaming |
| Toronto Central | City of Toronto* | North West | Northwest Rainy River Superior North |

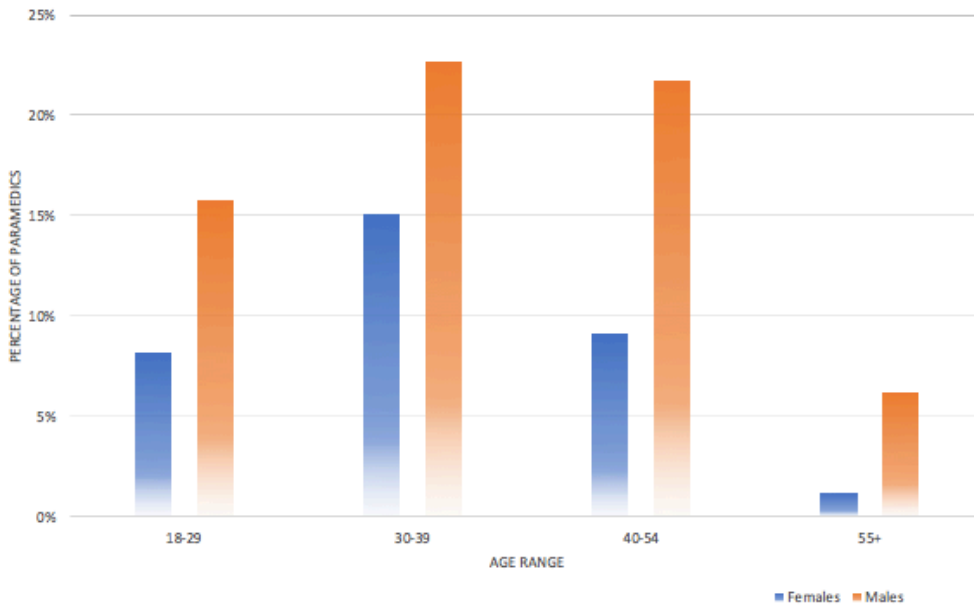
(MOHLTC, 2018g)

Mattawa General Hospital is subcontracted to provide ambulance services by the District of Nipissing.

Sensenbrenner Hospital is subcontracted to provide ambulance services by the District of Cochrane.

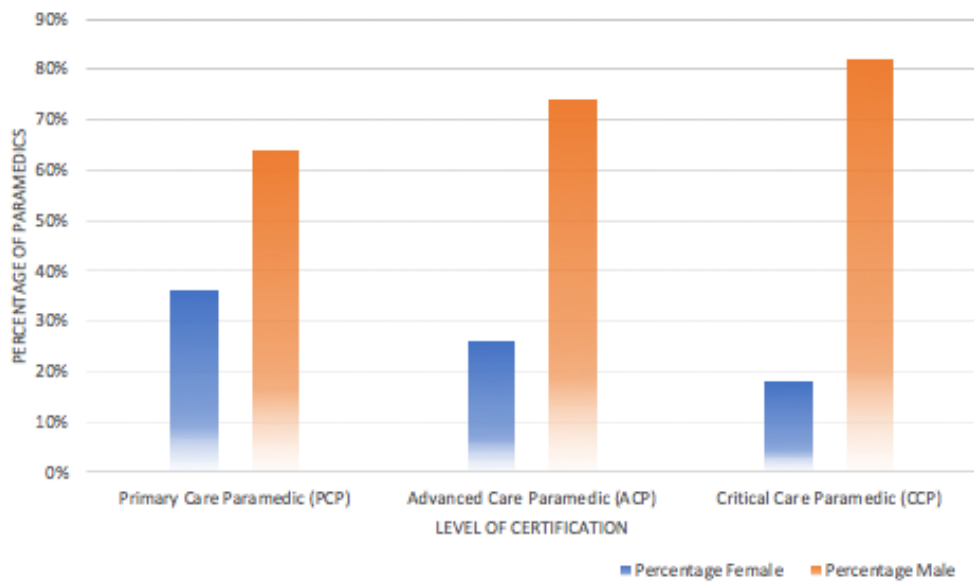
*Indicates that the paramedic service falls under the jurisdiction of more than one Local Health Integration Network (LHIN).

Figure 3.2. Ontario paramedic demographics: Age, sex - July 2017



(MOHLTC, 2018g, p.12)

Figure 3.3 Ontario paramedic level of certification by sex – July 2017



(MOHLTC, 2018g, p.12)

3.2.2 (b) *Case sub-units: Sites of study*

In respecting the anonymity of the paramedic services, paramedics and communities involved in the research, demographic and other details provided regarding each site are anonymized. The ‘world’ of paramedic services in Ontario is a small one, with many paramedics working in more than one paramedic service and connected to other services by few degrees of separation. Additionally, the sites involved include rural communities, where even greater challenges may exist in ensuring anonymity. In considering ethical challenges with anonymity in conducting health research Wilson-Forsberg & Easley (2012) discuss the particular challenges in rural and remote communities. They discuss the value of ‘deidentified case studies’ which can address the limitations to anonymity in rural and remote communities, however may lose specific histories and details of the place. I was attentive not only to patients’ mental health but also discussion of paramedics’ own experiences with mental health and their experiences in their place of employment. I have mostly deidentified the sites, while providing some details about each one. I chose not to identify the site or geography for each quotation or findings provided in order to respect confidentiality given the small sample size of services. Where there were true, noted differences in finding however, for example between rural and urban paramedic services, I make reference to the geography of the given site.

The research focuses on what programs or resources for mental health and psychosocial needs are currently provided by paramedic services in Ontario to address these calls. Most services in Ontario do not have specific mental health programs. Consequently, my selection criteria included paramedic services in Ontario, with at least one paramedic service engaged in a project or program related to mental health calls, and at least one service not currently engaged in a particular project/program.

Within Ontario, 3 most different paramedic services sites were selected on the basis of difference in geography between urban, suburban and rural communities, as well as difference in programs or support for mental health and psychosocial calls in the paramedic service. I document experiences within, between and across services to describe similarities and differences across Ontario, along with increasing the rigour of the findings.

Description of the site attributes are as follows:

Site 1 is a paramedic service based in a primarily urban area with some suburban and rural areas with an overall population density of 900/km² in its urban centre and under 150/km² in the surrounding communities. Primary areas of industry include manufacturing (10%), retail trade (11%), educational services (9.2%), and health and social assistance (14%) (Statistics Canada, 2016). This paramedic service addressed a high volume of mental health calls, piloted and established a program to address these calls, and had other community resources available such as through crisis response teams or police involved mental health response teams at the time of field research.

Site 2 is a paramedic service based in a rural area with a population density of less than 20/km². Primary areas of industry include agriculture, forestry, fishing and hunting (15%), manufacturing (11%), retail trade (10%), and health and social assistance (10%) (ibid). This paramedic service was not engaged with specific programming to address mental health calls, and beyond crisis line phone numbers it did not report specific community resources to aid in the management of mental health calls.

Site 3 is a paramedic service located in a rural and suburban area with a population density of just over 30/km². Primary areas of industry include agriculture, forestry, fishing and hunting (9%), manufacturing (19%), retail trade (10%), and health and social assistance (10%) (ibid). This paramedic service was also not engaged with specific mental health programming, however it reported it had access to some community resources such as hospital crisis teams or police-related services to aid in responding to mental health calls.

Included below are comparisons across the three sites for age, sex, housing, income and employment-related statistics for the communities served by each paramedic service (site):

Figure 3.4 Age of population, by site

| Site | Age |
|----------------|--|
| Site 1 | 0-14years: 16% 15-64years: 67% 65+: 17% 85+: 2% 100+: 0.02% |
| Site 2 | 0-14years: 17% 15-64years: 60% 65+: 23% 85+: 3% 100+: 0.02% |
| Site 3 | 0-14years: 18% 15-64years: 63% 65+: 19% 85+: 3% 100+: 0.03% |
| Ontario | 0-14years: 16% 15-64years: 67% 65+: 17% 85+: 2% 100+: 0.02% |

(Statistics Canada, Ontario. Census Profile, Catalogue no. 98-316-X2016001, 2016)

The table above (Figure 3.4) presents the approximate age breakdown for the communities of each site. Site 1, the most urban site is consistent with Ontario averages, and has the largest population of 15-64 year olds, whereas site 2, the most rural, has the highest proportion of 65+ year olds.

Figure 3.5. Sex of the population, by site

| Site | Sex |
|----------------|--------------------|
| Site 1 | Male: 49% |
| | Female: 51% |
| Site 2 | Male: 49% |
| | Female: 51% |
| Site 3 | Male: 49% |
| | Female: 51% |
| Ontario | Male: 49% |
| | Female: 51% |

(Statistics Canada, Ontario. Census Profile, Catalogue no. 98-316-X2016001, 2016)

The table above (Figure 3.5) outlines the approximate sex breakdown for the communities in each site – the same across all sites.

Housing:

Core housing need indicates that a household falls below the requirements in one or more categories of adequacy (not requiring major repairs), affordability (costs less than 30% of before-tax income), or suitability (sufficient bedrooms for occupants) (Canada Mortgage and Housing Corporation, 2018). Specific data regarding housing were not available for each site. It is worth noting however that Site 1 is among the communities with the highest proportion of households with core housing need in Canada (Canada Mortgage and Housing Corporation, 2018). The communities of the other two sites did not fall onto the scale of core housing need.

Figure 3.6 Proportion of Low Income, by site

| Site | Prevalence of low income based on LICO after tax (%) |
|-------------|---|
| Site 1 | 10.2 |
| Site 2 | 4.3 |
| Site 3 | 4.6 |

| | |
|---------|-----|
| Ontario | 9.8 |
|---------|-----|

(Statistics Canada, Ontario. Census Profile, Catalogue no. 98-316-X2016001, 2016)

As illustrated in Figure 3.6 the region for Site 1 had a higher prevalence of low income based on the LICO (low income cut-off) after tax than the Ontario average. The regions for Sites 2 and 3 were both below the Ontario average. In all three sites, the largest city or town within the region had a slightly higher prevalence of low income than the regional prevalence.

Figure 3.7. Employment rates (In the labour force) by site

| Site | Employment rates (In the labour force) |
|----------------|---|
| Site 1 | Participation rate: 64.1 Employment rate: 59.4 Unemployment rate: 7.4 |
| Site 2 | Participation rate: 64.4 Employment rate: 61.0 Unemployment rate: 5.3 |
| Site 3 | Participation rate: 69.8 Employment rate: 67.0 Unemployment rate: 4.0 |
| Ontario | Participation rate: 64.7 Employment rate: 59.9 Unemployment rate: 7.4 |

(Statistics Canada, Ontario. Census Profile, Catalogue no. 98-316-X2016001, 2016)

The table above (Figure 3.7) outlines the labour force participation rate, employment rate and unemployment rates for each site and the comparison with Ontario. Site 1 has the highest unemployment rate, on par with the provincial unemployment rate with sites 2 and 3 having notably lower unemployment, with site 3 being the lowest. Employment as a determinant of health offers insight into this determinant for the region of each site.

3.2.3 Recruitment

To conduct the ethnography, I contacted paramedic services management to gain approval. Given the diversity of organizational structures between paramedic services in Ontario, approval was obtained from either the chief, deputy chief, commander or equivalent. I had in-person or phone communication with four paramedic managers to discuss their interest in participating in the research. Three confirmed their willingness to participate. The remaining manager indicated an interest in the research subject matter and advised they would need to follow up with their union. Despite a follow-up email with this manager, there was no further response and no specific reason for not participating was indicated. For all three services that were recruited, I held in-person meetings with at least one member of management prior to commencing the ethnography to establish the study flow including scheduling observation shifts and recruiting interviewees.

3.2.4 Ethnographic sources of data

Ethnography highlights the importance of context in research, exploring connections between day to day occurrences and broader structures and cultural formations (Savage, 2006). In particular, within ethnographic research, participants' experiences and perspectives are highlighted (Quimby, 2006), a feature that is particularly important for gaining a comprehensive understanding of the context for both paramedics providing care as well as those receiving care. Given the identified challenges in quantifying and qualifying mental health calls (Prenner & Lincoln, 2015) and working toward defining what constitutes a mental health call, ethnographic research allowed for a qualitative analysis of paramedicine calls and the conditions within which they occur. This case study incorporated both qualitative interviews and observation as well as the collection and analysis of legislation guiding paramedic practice, and documents related to paramedic program curriculum.

3.2.4 (a) Interviews and focus groups

I conducted interviews (n=46) with front-line paramedics, paramedic services management, particularly those engaged with managing mental health calls; college paramedic program educators; as well as directors and managers of paramedic Base Hospital programs within Ontario (Appendix IV). This case study employed key informant and small group

interviews, depending on the scheduling and availability of interviewees. An advantage of focus groups is the opportunity for exchanging and producing ideas (Litoselliti, 2003), and to determine the key themes and range of ideas on an issue (Krueger & Casey, 2000). The intent of groups interviews for paramedics was both for convenience in scheduling and availability as well as creating the opportunity for an exchange of ideas about their experiences with mental health and psychosocial calls. Given the challenges of shift workers' willingness and ability to participate in a group at a set time, I conducted interviews to allow for spontaneity, flexibility, and privacy when discussing certain topics such as working conditions, satisfaction with training provided, perceptions of paramedics' ability to manage these calls, or the possibility of paramedics discussing their experience with mental health more personally. Additionally, informal discussions occurred, such as in the hallways of hospitals or around stations, where paramedics briefly shared thoughts or experiences around mental health or psychosocial calls. Such informal discussions were subsequently documented in field notes. Given the complex schedules of paramedics, no formal focus groups were scheduled. Small group interviews occurred however, on the occasions that more than one paramedic was available in a station and wanted to both speak with me at the same time. This option allowed for flexibility when determining that it was going to be very difficult to schedule a focus group to which multiple interested participants would be able to attend given their shift work schedule. Additionally, it meant that in several cases where there was more than one paramedic present and interested in an interview and wanting to participate at the same time (either for comfort or for timing's sake), it was possible to conduct a small, informal group interview. This option provided some slightly different dynamics with input from another paramedic occasionally stimulating the discussion in different ways. Including the option of group and solo interviews in the methods increased participation from a broader spectrum of participants, where participation may have been impaired by scheduling, timing or privacy concerns (Carter et al., 2014).

All paramedics at the sites were contacted by e-mail using my template (Appendix III) by a member of management, distributed to the entire paramedic service. The email describes the nature of the research, requests their participation in an interview, and provides my direct contact information. In some cases, individuals chose to respond to the member of management, who then forwarded their e-mail to me. Eligible participants included any paramedic (primary, advanced or critical care). Ultimately, I interviewed 31 front-line paramedics.

Interviews were also sought with key informants who could speak to issues, circumstances, policy and practice across Ontario such as about training, management, and structures in place guiding paramedic practice. Case interviewees included: paramedic service management (n=5) from five different paramedic services across Ontario, educators at paramedic colleges (n=5), and Base Hospital directors/physicians (n=5). Recruitment was solicited via e-mail and/or phone. Paramedics and paramedic services management interviewees were drawn from at least 9 paramedic services across Ontario (including paramedics who identified they worked for other paramedic services).

A modified snowball sampling technique for the sites as well as the individual interviewees was used to recruit participants for interviews/focus groups, building contacts for potential interviews within and associated with the services. In total, 46 front line paramedics, educators, members of paramedic services management, and Base Hospital directors or physicians were interviewed following semi-structured interview guides (Appendix V).

Interview participants either responded to my request for interview via e-mail, in which case an interview was scheduled at a planned date and time or the interviews took place spontaneously during down-time on my observation shifts. Scheduled interviews took place at a local public library in a quiet, private space. Some participants requested the option of completing an interview over the phone. In one case, a participant requested we meet at a restaurant, and in this case we were located in a booth at the corner of the restaurant, offering some seclusion from others. For those interviews that took place during down-time on my observation shifts, I advised paramedics in the station that I was also aiming to carry out interviews with paramedics if they had time and were interested. Some of these paramedics also went and sought other paramedics who they thought might be interested. These interviews were carried out in the stations – sometimes in an enclosed office or kitchen space, or more openly in the station. All participants were offered to go to a more private space, and I left the choice of where in the station to carry out the interview up to them. If anyone else entered the space where the interview was being conducted, I offered to pause the interview and resume when the space was private again.

Prior to beginning the interview, I presented the consent form to the participant and went through it with them, highlighting key areas such as their voluntary participation and confidentiality. I then gave them as much time as they wished to go through the form and

answered any questions they had. For the several participants that wished to conduct the interview over the phone, I went through the consent form verbally and e-mailed them a copy of the form – the verbal consent process was recorded in the audio recording and some form of written consent was obtained. All participants provided consent to have the interview audio recorded and two audio recorders were used. Participants were advised when the recording was started and stopped and also advised that they could request we stop the recording at any time. At the conclusion of the interview, I answered any questions asked by participants and also provided the \$10 Tim Horton's gift card incentive.

In the case of one service, all interviews conducted were arranged by scheduling ahead of time. During the observation shifts, the paramedics were too busy, calls too frequent and downtime too limited for it to be appropriate to conduct interviews. It was however an opportunity for good discussion that I documented in field notes, but conducted no formal interviews during observation. Unfortunately, this challenge limited the number of formal interviews I was able to conduct with paramedics in this service, which was particularly unfortunate as it had a particularly significant issue with mental health call volume. In the other two services, while some interviews were scheduled and conducted away from work time and places, a good number of interviews were conducted during observation, when there was downtime at the stations, as was far more the case in the less busy, rural services. It was easier to conduct these interviews with paramedics available around the station as they were less busy, however also dealt relatively less frequently with mental health calls given the slower pace in their services.

Having the opportunity to conduct interviews with paramedics met by chance in the stations who were available and agreed to participate in an interview also may have offered a different perspective, than those that were willing to come in on their days off, specifically for an interview. At certain scheduled interviews for example, paramedics stated they travelled in excess of 30 minutes to attend the interview. While this signified the importance of participating in the research on this subject for them – an important finding in itself, it may have represented somebody attuned to the issue, and a potentially different type of participant from those met by chance in the stations. Ultimately, it was important to have the flexibility in terms of solo and group interviews and locations of each, with this particular population of participants. In the future, it would be ideal to find an opportunity to speak with more paramedics in the busier

service with more mental health calls. This would however, likely present additional challenges no matter what the arrangement.

The sampling of participants with regard to gender was random and of convenience. While the makeup of the Ontario paramedic workforce overall is 34% female and 66% male (MOHLTC, 2018g), this varies region to region and I proceeded with interviews to the point of saturation. A total of 52% of the interviewees were women and 48% were men. While this did not exactly match the sex composition of the paramedic workforce, it offered significant input from both men and women and I achieved saturation in the interviews. Due to a relatively smaller proportion of females in certain management positions in paramedicine, I will not report any specific management positions in relation to gender so as to ensure confidentiality.

3.2.4 (b) Observations of paramedics' work

Observations offer the researcher the opportunity to observe and document the work organization and the circumstances across a range of calls, whether mental health, medical or trauma, as well as varied living and working conditions. Observations in the field allowed me to observe social and environmental contexts, (Yin, 2014) and to document the working conditions in which paramedic calls take place, in relation to the work of paramedics. For each of the three sites I requested the opportunity to carry out observation shifts. I provided several potential dates for observation, and they then confirmed the specific dates and station locations. The services generally indicated that they would aim to place me with a crew they felt would be receptive to having an observer with them and/or might have some interest in the research. The services generally offered the opportunity for observation for 3 or 4 shifts with the service. In each observation shift (n=10) I attended, I was placed with multiple crews. I observed 3 shifts in Site 1, 4 shifts in Site 2, and 3 shifts in Site 3. I observed calls across all three sites (n=20) (Appendix VI).

Prior to attending my observation shifts, I requested that the paramedic service advise those with whom I was scheduled about the planned observation, as well as advise them that their participation was voluntary and that they were not obligated to have me present. In several cases, the service asked me to provide them with an e-mail outlining this information. The members of management advised me that they would provide this information to the paramedics

ahead of time, and in two of the three services, management advised that they e-mailed the entire service to inform them that I would be out on the road and at stations observing on calls.

Observation shifts were scheduled for either 8 or 12 hours per shift. For each shift, I arrived approximately 10-20 minutes prior to the start of my shift. In most cases this coincided with the start of the paramedics' shift. I gained entry to the station by knocking or ringing the bell at the station and was let in (as all stations are locked to the public), by paramedics or other staff. I identified myself and my reason for being there. In some cases, they were not aware ahead of time that I would be attending that day. As paramedics have a variety of tasks to carry out at the start of their shifts, many of which are time sensitive, I gauged the timing and opportunity to elaborate on the research with them, and to provide them the consent form, as they prepared to begin their shift. Each paramedic or crew with whom I was observing on their truck was provided with a consent form and I obtained consent prior to attending any calls with them. After this introductory and consent-gaining procedure, I advised paramedics to let me know where I ought to be in their station and during any observation period such that I would not be in their way, or encroaching on their personal space, as the station represents something of a home and refuge for paramedics between calls. Observation throughout the shift involved me shadowing the paramedic throughout their regular duties – in the ambulance, on scene, at stations and at the hospital etc. When in the ambulance, I sat where directed by the paramedic crew – which in all cases was in the rear jump seat (patient compartment area) to and from the call. Given my experience as a paramedic, I aimed to position myself out of the way of the paramedics in the stations, on scenes and in the truck, and followed their instructions as directed. At no time did a paramedic, patient, family member or other staff ask me not to be present during a call or on a scene.

Despite being a certified paramedic, I advised crews that I was present as a researcher and not working in any capacity as a paramedic. I was not certified by the base hospital in the regions of study and was not able to practice as a paramedic during the observation shifts. This was explicitly established with the service and with the crew with whom the shift was completed, prior to beginning observation. Given the nature of paramedic work, being called to medical and trauma emergency situations with high demand and low resources, in certain circumstances, it was possible for a paramedic to direct me to assist, in the capacity of a bystander trained in first aid. In such a circumstance, I would be acting under the *Good Samaritan Act* (2001) and not as a

paramedic. Such circumstances were entirely at the direction of the paramedics and appropriately documented in field notes.

My data collection during the observation portion of the research involved taking field notes either on note pad, or on electronic device when in the back of the truck or at stations. As outlined in the consent form, participants were offered a \$10 Tim Horton's gift card to thank them for having me observe with them, and this gift card was provided either during the shift (if stopping for a coffee break at a Tim Horton's) or at the completion of the shift. At the end of each shift, I thanked paramedics for having me observe with them and advised them that they were welcome to e-mail me with any follow-up thoughts or questions.

Several challenges arose with regard to site observations. The challenges revolved around the crew's awareness ahead of time that I would be attending as an observer (pending their consent) as well as the unpredictable nature of the work and the likelihood of receiving calls that were relevant to the research while I was observing.

While in each of the services, I confirmed with management that they would advise crews ahead of time that I was being scheduled to observe with them, it seemed that the message often did not reach the crew prior to my arrival. Some of the challenge was that the crew was notified by e-mail, however had not yet checked their e-mail, or in some cases, it seemed that the message may not have been passed on. Knowing that shift change time can be busy, particularly if the crew receives an early call out of the station, I felt some discomfort when crews did not have any warning that I was coming as it was another consideration for them at their already busy start of shift. I was careful to emphasize that they were not obligated to have me as an observer, and it was completely voluntary on their part. I did however wish they had had additional warning so that they did not feel they had to make this decision with me already present. While the circumstance did not arise that any paramedic or crew did not consent to have me along for observation, I had already determined that I would simply advise management that I was unwell and unable to remain for the shift, so that the crew would not receive any negative feedback from management for having refused me as an observer.

I was quite fortunate on many of the shifts that I observed that there were mental health and psychosocial-relevant calls that occurred (Appendix VI). That said, there were shifts in some of the more rural services where there were no calls at all, or those that did occur were not particularly relevant to the research. These shifts were still of benefit in having the opportunity

to discuss with that crew (and other crews we encountered throughout the day) their perspectives on mental health calls and the nature of their work.

3.2.4 (c) *Legislation and document analysis*

To explore training within paramedic programs at the college level, curriculum documents were sought from the public paramedic colleges within Ontario. The director of all paramedic programs in public colleges in Ontario was contacted via e-mail, to describe what training around mental health and psychosocial care their paramedic students receive, and to provide reference material used by students and to share their documents (Appendix VII).

During the time of the study, the Ontario colleges experienced a substantial labour disruption mid-year (CBC, 2018b) resulting in significant semester and course pace adjustments, as well as pressures for educators. While all 18 paramedic colleges (excluding private colleges) were contacted to share information regarding their curricula, 5 paramedic programs educators were interviewed from 4 colleges. Along with educators, all individuals interviewed for the study throughout Ontario were asked about the mental health training and education for paramedics.

Three colleges provided curriculum related documents in response to the e-mail request, including the current MOHLTC curriculum guidelines and college-specific course outlines. Documents for analysis included: *The Basic Life Support Patient Care Standards (BLS-PCS)* (2018) and *Advanced Life Support Patient Care Standards (ALC-PCS)* (2018), the *Ambulance Act* (1990), and the *Ontario Mental Health Act* (1990). Additional documents included for analysis were those provided by paramedic services such as alternate destination guidelines and program statistics. I analyzed these documents for any content relevant to paramedic practice and mental health or psychosocial calls to further inform findings from interviews and observation. In reviewing the content relevant to this subject area I then analyzed for key themes. Further description of the data analysis process occurs in the subsequent section.

3.3 Data analysis

Mental health and substance use related calls as well as ‘psychosocial calls’ all took place while I was conducting observations, which allowed me to document acute crisis and less acute distress on the part of the patients. As described in Chapter 2, the terms ‘mental health calls’ and

'psychosocial calls' were used to include psychological and/or social factors, and not primarily medical or traumatic calls. As the aim was to gain further understanding of this field, an approach was needed that would move beyond attempting to quantify mental health calls in this setting, and rather to explore what these types of calls include, what is driving these calls, how they are managed as well as where challenges exist. While an increase in call volume has been identified in literature, challenges have been identified with attempting to quantify and qualify mental health calls based on patient call reports (PCRs) as mental health concerns may not be the primarily identified component of a call, and this assessment relies solely on what is documented in the report (Prenner & Lincoln, 2015). As such, I considered other means of exploring this increase in mental health calls, as well as how and why this may be occurring and potential outcomes. In speaking of the importance of qualitative research in addition to a quantitative understanding of a situation, Bernard (2013) identifies the role of qualitative research "to explore the causes and consequence" (p.23) and qualitative research has been identified as "essential to the knowledge development of health care disciplines," (Morse, 1994, p. 2 in Curtis, Gesler, Smith and Washburn, 2000). The gaps in the research around mental health calls, as well as the theory (feminist political economy and SDOH) guided the qualitative analysis.

In order to carry out analysis, interviews were verbatim transcribed. I transcribed 19/46 of the interviews, while the remaining audio recordings were transcribed by a transcription service. All field notes were transcribed and were read through at least once prior to beginning coding. Thematic coding was performed using NVivo (NVivo for Mac Version 11) software following a list of codes as well as allowing for themes to emerge (Appendix VIII).

As Braun and Clarke note, "A theme captures something important about the data in relation to the research question, and represents some level of patterned response or meaning within the data set. (Braun & Clarke, 2006, p.82)". The theory guiding this research was used to create the initial list of themes and refined by ideas from field notes. During the process of data collection, transcribing and reading, I made notes of a variety of additional themes to generate the list of thematic codes.

Importantly, the thematic analysis I performed was not carried out and data were "not coded in an epistemological vacuum" (Braun & Clarke, 2006, p.84). Epistemological and other assumptions as well as the theoretical lenses were explicit during the processes of data collection and thematic analysis (ibid). Not only did I bring prior knowledge and experience in the field of

paramedicine to this study, but also acknowledge that it is driven by a feminist political economy lens, with an emphasis on the SDOH as it pertains to mental health. Theory guided my research questions and analysis, including which themes were of greater interest and I found to be more noticeable. Additionally, this was guided by my exploration of the current literature in this area, as well as the gaps in that literature. Having conducted all of the interviews, observations and document analysis, the process of coding, determining themes and further analyzing these themes was an iterative and repeated process, employing a constant comparative method (Glaser, 1965), carried out to the point that refinements were no longer adding substantial insights or content relevant to the research questions (Braun and Clarke, 2006).

3.4 Reflexivity

A variety of challenges presented themselves to me both prior to and during the research beginning with my initial hesitation to carry out ethnographic research in the paramedic services setting because of my training as and teaching of paramedics. In this section, I address how my being a paramedic affected the study.

3.4.1 A Paramedic observing paramedic services

When considering different methods that might be employed to carry out the research, when the suggestion of observation in paramedic services was presented in addition to interviews and focus groups, I initially did not feel it was something that would be feasible. My concerns lay in several areas: first and foremost, the tension of feeling as though I was an ‘observer’ amongst my colleagues, the current strict limitations put on ride-alongs in many paramedic services, and the tension I might feel if in the field on a high acuity call being present, yet not able to use my paramedic skillset and ethical challenges that could arise. I worked through these considerations through discussion with a trusted, senior, paramedic colleague, discussion with my supervisor, and reviewed literature based on observational experiences of health care providers in their own field (Bailey, 2007; Roberts et al., 2013; Pope, 2005).

3.4.2 ‘Observing’ colleagues

My hesitation to observe amongst colleagues was the most challenging for me. My supervisor however reiterated that the focus of the research was not on individual paramedics,

but rather on the conditions in which they work and provide care, exploring the tensions and limitations that are present in that. Directly incorporating that into the consent form and into my introduction to crews with whom I might observe played a crucial role in easing my discomfort and I suspect theirs also. Furthermore, highlighting the confidentiality of both the paramedic services as a whole as well as paramedics individually was also important. Additionally, the selection of research sites not near to my own service of employment was important for some distance, and also to ensure it was a service in which I had no prior experience.

3.4.3 Accessing the field

The concern I had with regard to gaining access to the field for observation was not irrelevant, but something which was feasible to overcome. In recent years, it has become less and less common and often not permitted (depending on the paramedic service) to have someone attend a “ride along” on the ambulance. This has been largely based in concerns around *PHIPA* (2004) and the importance of protecting personal health information, as well as concerns with liability and risks of being out in the field. Receiving the conditional ethics approval from the university (pending the approval of the service), was important, so as to be able to present the service with the fact that the research had been reviewed by an ethics body. While there was some initial hesitation around the feasibility of my observing by the services, I was able to provide sufficient information and documentation for this to be feasible. The Ministry of Health requirements for anyone to be present even as an observer on an ambulance, includes a lengthy and comprehensive set of documentation with regard to immunization and health history, as well as requirements such as holding a CPR certification. In all cases, management indicated that this was significantly more straightforward given that I am currently a working paramedic and as such had this documentation ready and assembled to provide.

In one case I was required to sign a waiver of liability and understanding of the risks associated in order to participate in observation. Another service requested I be able to provide proof of insurance, such is the case when paramedic students ride along in the field and have Workplace Safety & Insurance Board (WSIB) coverage in the case of incident or injury. This proved more challenging than anticipated as it took some weeks to determine whether and to what extent I did in fact have coverage in this capacity as a graduate student – an issue it seemed had not been previously or perhaps frequently explored in graduate student research at my

institution. As the insurance coverage provided as a graduate student was not relevant to the type requested by the service, I requested the option of providing and signing a liability waiver for the service with an understanding of the risks present in the field. I was able to do so, and able to proceed with observation in that service. Given my work experience and familiarity with what the risks entailed, I decided that I was comfortable proceeding in this way.

3.4.4 My limitations – Being a paramedic but only observing

Finally, there was the concern I had with regard to ethical tensions I might feel if present for a call, yet not able to assist in my capacity as a paramedic. The intent was for me to be present as an observer, however I was aware of how difficult it could feel, given the nature of the high intensity, low resource setting of paramedic work, to not offer any assistance. It was important for me to know that I would not have to be completely unhelpful to the crew allowing me to observe with them, in high intensity, high demand circumstances. This was a particularly relevant consideration given the rural nature of some of the services, where additional resources are often not available for crews, or are a significant distance away. I found also, on observation shifts, that being able to carry a bag, or fetch a piece of equipment as directed by the crew helped me to feel better about being present on the scene as an additional consideration for the crew, and also built good will with the crew in being able to make myself useful. A number of the paramedics expressed greater comfort given I am a paramedic and stated that they didn't have to worry about "babysitting" me on scenes.

I was pleased to have worked through many of these concerns prior to the research beginning and in carrying out the research. I found a number of those with whom I observed were quite interested in the research and seemed interested to have an opportunity to discuss these types of calls and their feelings around them. It was frequently expressed both by management arranging observation as well as by paramedics with whom I was observing, that the fact that I was a working paramedic and had experience in the field made them much more willing to allow the observation shifts.

3.4.5 Language use

The language I used when asking different questions in interviews, as well as when describing the nature of the research was important. When asking questions regarding

“psychosocial calls,” a lack of familiarity with that term by paramedics often created discomfort and it seemed participants felt less like an “expert” in their field. As interviews went on, I modified the question to involve a description of what I might understand “psychosocial calls” to be, and this elicited far greater response and responses more relevant to content I was hoping to explore.

An overall challenge, was when describing the research as related to ‘mental health calls in the paramedic services setting.’ Both management and front line paramedics alike frequently assumed it to be regarding paramedics’ own mental health – a finding to be explored further in Chapter 7 in greater detail. I found even upon explaining in some detail, that I was referring to the patients paramedics might see, many still remained locked in to the understanding that it was regarding paramedic mental health. This seemed largely due to the current climate of discussion around first responder mental health and Post Traumatic Stress Disorder (PTSD). Using terminology like “psych calls,” as is more common language in the paramedic setting, was not what I intended to do, given the negative connotation around this, particularly as related to critical mental health literature. At times, however, I resorted to including that terminology in my explanation so as to be clear on the subject of the research.

3.4.6 Interest from additional paramedic services

A chief of one service stated that they found the research subject to be an important issue that has come up frequently and felt it was important for other services to hear about the research. They invited me to speak and present my research at a regional meeting. I presented at the meeting and the director of the board of the group sent my slides out to all services that had been unable to attend. I was contacted by other paramedic services in Ontario.

3.4.7 Limitations to the study

An important study limitation was the lack of inclusion of the perspectives of the recipients of care. As the study was designed, it was not also possible to interview or speak extensively with the patients encountered during observation, given the acute, crisis nature of paramedic response to people with mental health concerns. The perspective of those in crisis or those using paramedic services as related to a mental health concern is undoubtedly a critical perspective to include for a full understanding of care in this area in the prehospital setting.

Future research in this area warrants the inclusion of the care recipient's perspective, an approach that would require great care, given the acute and potentially traumatic experiences associated with use of paramedic services for those with mental health concerns and in crisis.

3.5 Conclusion

This chapter has outlined the case study research design and methods employed in this study. The theoretical lenses guiding both the research design, process and analysis were highlighted. The process for engaging paramedic services and associated bodies in this research was discussed, including recruitment, research procedures, as well as site selection. A case study approach to this research offered means to explore the area of mental health and psychosocial calls in depth, using a variety of perspectives and data sources, as well as exploring relevant context for calls, care and practice in this area. The varied methods of observation, solo and group interviews, and document analysis allowed for the subject to be explored at the level of the front line workers, those managing the front lines, the broader conditions of work and conditions in which these calls take place, as well as at the structural, policy and procedural level. A limitation to the study is the lack of inclusion of the recipients of care, a perspective that would be an important addition to future research.

Chapter 4: Context – Paramedic Work and Mental Health Care Work in Ontario

4.0 Introduction

In this chapter, I document paramedics' role and paramedic services' organization in Ontario to show the conditions of work and to frame the parameters of their mental health and psychosocial care work. First, I provide a brief history of the origins of this relatively new profession, along with a description of the conditions of this work and its standards of practice. Second, I outline the role, scope of practice and training of paramedics. Third, I briefly address the evolution of paramedicine as it has expanded into different domains, beyond 9-1-1, emergency medical response. I next provide a description of what constitutes mental health and psychosocial care work in paramedicine in the literature compared to the perspectives of front-line workers. Finally, I offer one call that occurred during a shift observation as an example of this work.

4.1 The origins of paramedic work in Ontario

The origins of paramedic or ambulance services work in Ontario began in the late 1800s. As physicians provided care in people's homes, the purpose was exclusively transportation of those who were dying or deceased to a funeral services provider when people had died or physicians had no remaining options for care. Toward the end of the 1800s, formalized basic first aid training was provided to Toronto Police Services, as the operators of 4 horse-drawn ambulances in Toronto. In 1905, ambulance service providers across Ontario were funeral home-based or private ambulance providers, and in the 1930s, additional ambulances services were established through hospital based systems, the fire department and corporate-based providers. This variety of providers existed until the formal regulation and control of ambulance services by the provincial government in the 1970s (Ontario Paramedic Association, 2018).

Starting in 1967, Doctor Norman McNally, a retired Army surgeon, established a standardized, 160-hour training course for ambulance staff in Ontario – beginning the standardization of ambulance care. Community College training was established in the 1970s as the Emergency Medical Care Assistant (EMCA) course, as well as the beginning of advanced paramedic training for some ambulance officers and flight ambulance services. The 1970s also saw the entry of women into the ambulance service, with Halton-Mississauga (currently Peel

Region Paramedic Services) hiring the first female ambulance officer. The Ontario *Ambulance Act* (1990) presented the first standardized legal requirements for training, equipment, inspection, documentation and records for Ambulance services. At this time Ontario had more than 200 Ambulance services and in 1982, ambulance services became accessible by 9-1-1. In 1995/1996, Advanced Life Support Skills training for all ambulance staff was established in Ontario. Ambulance staff began to be trained in defibrillation for cardiac arrest, followed by the ability to administer 6 medications for limited emergency medical conditions. Many ambulance services became ‘emergency medical services.’ In 2005, The Professional Paramedic Association of Ottawa advocated for recognition of ‘paramedic services’ terminology which has since expanded to many regions across the province (ibid). The switch from Emergency Medical Services to Paramedic Services as a title was intended to clarify who is arriving and providing care when 9-1-1 medical services are called, reflecting the evolved role and degree of qualification of the care provider (Edmiston, 2014).

4.2 Conditions of paramedic work in Ontario

In the following subsections I outline the conditions of paramedic work in Ontario including: the settings in which care is provided; the standards guiding paramedic practice; physical demands of the work; and finally issues of paramedics’ own mental health.

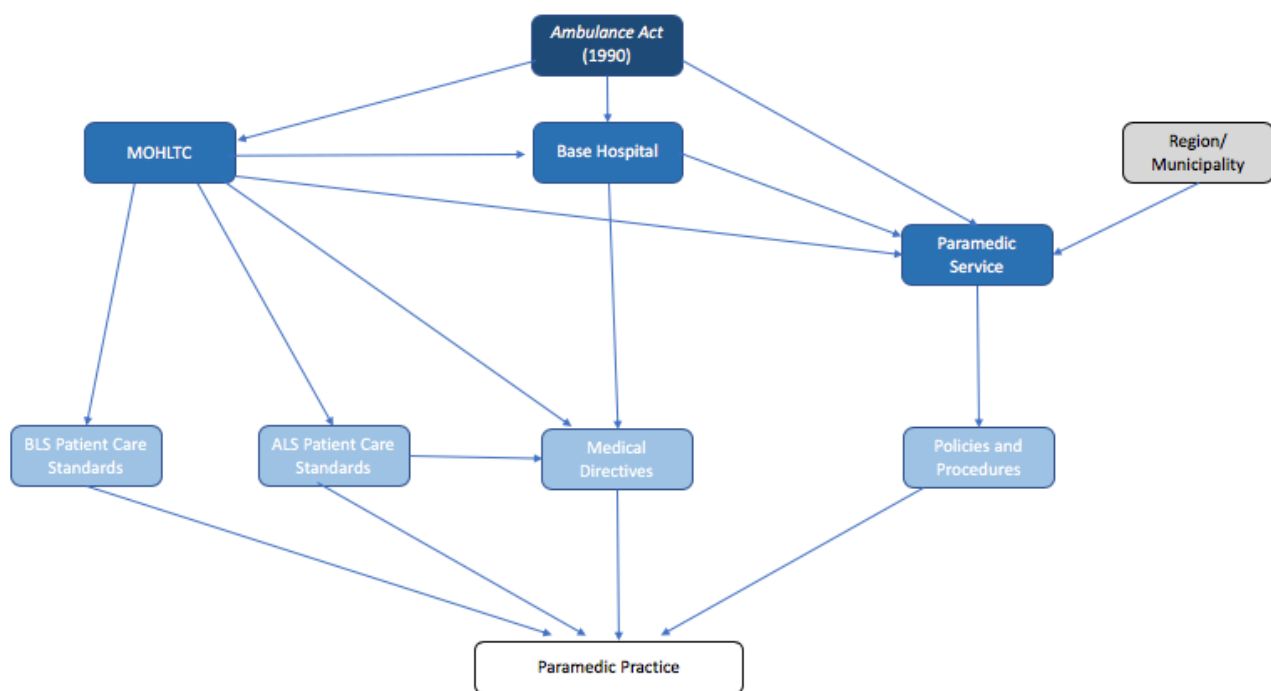
4.2.1 Settings for care provision

The working conditions of paramedics in Ontario vary with the place, geography of the region, as well as service infrastructure and managerial approaches. Paramedics are in the unique position of providing care in people’s own homes and within the community (Verma et al., 2018). This setting involves an unpredictable and uncontrolled work environment with locations for care provision including private residential homes, Long-Term Care facilities, social services centres, shelters, at the roadside, in back alleyways, at public events and in recreational facilities including in the back of the ambulance, and en route to hospital (Corman, 2017). Metz (1981) describes paramedics’ work setting as the “backstage of social life,” interacting with individuals whose defences are down and are in crisis, and paramedics as regularly encountering situations others would find unusual. From this variety of call settings, when departing the scene of a call, paramedics in Ontario are mandated to transport patients to a

hospital ED, regardless of the severity or urgency of a situation (Ambulance Act 1990; Bigham et al., 2013; Corman, 2017), although certain exceptions currently exist and legislative changes allowing for the possibility of transporting to alternate destinations from the ED are underway (Ambulance Act 1990, amendment 2017).

4.2.2 Regulatory standards of practice and medical oversight

Figure 4.1. Oversight of Paramedic Practice in Ontario



There are multiple bodies guiding paramedic practice in Ontario as depicted in Figure 4.1. Paramedics are overseen provincially by the *Ambulance Act* (1990), and the Ministry of Health and Long Term Care (MOHLTC); by the Base Hospital; and by the paramedic service within a particular region or municipality. The MOHLTC, the Base Hospital and the Paramedic Service are oversight bodies, and have their responsibilities and authorities outlined in the *Ambulance Act* (1990). From each of these oversight bodies exist standards, policies and directives guiding paramedic practice, many of which are interrelated. In addition to the BLS Patient Care Standards and the ALS Patient Care Standards, additional standards exist, published by the MOHLTC, as outlined in the *Ambulance Act* (1990): Land Ambulance Certification

Standards; Ontario Ambulance Documentation Standards; Ambulance Service Communicable Disease Standard; Air Ambulance Certification Standard; and Patient Care and Transportation Standards. Furthermore there are different advisory bodies not included in this diagram for example the Ontario Base Hospital Group is an advisory body to the MOHLTC with regard to paramedic practice. This section outlines the role and nature of these oversight bodies specific to paramedic practice.

Paramedic practice in Ontario is guided by two standards from the Emergency Health Services Branch of the Ontario MOHLTC, via the Basic Life Support Patient Care Standards (BLS PCS, 2018) and the Advanced Life Support Patient Care Standards (ALS PCS, 2018).

The Basic Life Support Patient Care Standards (the “Standards”) is the Ministry of Health and Long-Term Care (MOHLTC) standard by which paramedics shall provide the minimum mandatory level of patient care in Ontario.

When providing patient care as per the Standards, a paramedic shall ensure that the patient simultaneously receives care in accordance with the Advanced Life Support Patient Care Standards (ALS PCS).

(MOHLTC, BLS PCS,
2017)

The ALS PCS reflects current practices for paramedics in Ontario and provides benchmarks for paramedic performance. It also communicates the standards of practice and care by paramedics in Ontario to paramedics, patients, other disciplines and the public in general.

(MOHLTC ALS PCS,
2017)

In order to practice as a paramedic and perform medical acts, a paramedic must 1) receive certification from the MOHLTC; 2) maintain current employment by a certified ambulance service; and 3) have authorization by an Ontario Base Hospital program Medical Director (MOHLTC, 2018d). As discussed in Chapter 3, paramedics may not practice without authorization by a Base Hospital, as physicians provide medical oversight and delegation of medical acts. Paramedics in Ontario are not currently self-regulated and do not currently have a College of Paramedicine (Ontario Paramedic Association, 2019). As such, paramedic practice is

guided by medically authorized protocols to manage the patient's condition or complaint (MOHLTC, 2018b). Medical authorization of this practice is provided by a Base Hospital, a body which provides medical direction, oversight and advice for paramedics providing prehospital care (Ontario Base Hospital Group, 2018). There are eight Base Hospitals within Ontario: Central East Prehospital Care Program; Hamilton Health Sciences Centre for Education and Research; Health Sciences North Centre for Prehospital Care; Northwest Region Base Hospital Program; Regional Paramedic Program for Eastern Ontario; Southwest Ontario Regional Base Hospital; Sunnybrook Centre for Prehospital Medicine and Ornge. Paramedic practices while on a call are documented through an electronic Patient Care Report that is submitted to their paramedic service (Corman, 2017). Quality assurance is provided by the Base Hospital, which also provides ongoing continuing training and education for paramedics to maintain and update their skillsets and knowledge (Ontario Base Hospital Group, 2018). Additionally, oversight of paramedic services is with the MOHLTC Emergency Health Services Branch. Under the *Ambulance Act* (1990), this branch is responsible for publication of standards for patient care, documentation, safety, equipment requirements and transportation (MOHLTC, 2018g). The paramedic service is governed by the *Ambulance Act* (1990), the MOHLTC, the region or municipality (through its funding, policies and procedures) and also the Base Hospital, which delegates medical acts to the service's paramedics.

4.2.3 Physical demands

There is a significant physical component to paramedic work, including activities such as conducting physical assessments, managing airways, cardiopulmonary resuscitation (CPR), patient repositioning and immobilization, as well as lifting and moving patients and equipment (Coffey, MacPhee, Socha & Fisher, 2016). The physical work of paramedics has been described as having “occasional bouts of high physical strain in a predominantly sedentary occupation” (Gamble et al., 1991 in Coffey et al., 2016, p. 355). Recent data indicates paramedics' rate of injury as seven times that of the average working population (Coffey et al., 2016), and paramedics have the highest percentage of early retirement, largely resultant from musculoskeletal disorders (Prairie & Corbeil, 2013). The nature of the unpredictable work environment, and need to provide care, extricate and transport patients in any number of different settings creates inherent physical demands in this work. Paramedics additionally work shift

work, something found to have effects not only on sleep quality and quantity, but implications for health and wellbeing both physically and psychologically (Sofianopoulos, Williams & Archer, 2012). The physically involved nature of paramedic work is an important aspect of the conditions of work, with not only mental and emotional but significant physical demands. This affects the ways in which paramedics perform work; the conditions and pressure under which they provide care and make decisions; as well as their ability to continue work in their given profession or not in the case of injury.

4.2.4 Paramedic mental health – the current climate in paramedic services

With regard to the working conditions of paramedics, the mental health of paramedics has increasingly come into focus. In recent years, there has been a substantial movement in addressing first responder and specifically paramedic mental health in Ontario. Organizations and campaigns such as the Tema Conter Memorial Trust *Heroes Are Human* campaign (Tema Conter Memorial Trust, 2018), #IVEGOTYOURBACK911 (#IVEGOTYOURBACK911, 2018), #SICKNOTWEAK (SICKNOTWEAK campaign, 2016) have led to increased awareness of mental health needs for paramedics and increased presence of the topic in the media. Media reports present paramedic suicide rates in Canada as 5 times the national average, with one in four paramedics developing PTSD in the course of their career (CBC, 2018a) and suicidal thoughts are far higher among paramedics than even among police and firefighters (Freeze, 2018). Paramedics are found to be one of the professions most vulnerable to mental health concerns (Gayton & Lovell, 2012) and are at high risk for diagnosis of posttraumatic stress, depression and anxiety in relation to both exposures to critical, traumatic incidents, as well as chronic workplace stressors (Donnelly, Chonody & Campbell, 2014).

Paramedics have traditionally had a militaristic type culture of stoicism, with mental health needs largely not open for discussion (McNamara, 2016; Williams, 2012). In recent years, claims for operational stress injuries (a term that encompasses mental health concerns arising as a result of trauma experienced in the workplace) have been on the rise, and there has been increasing attention to paramedic mental health and calls for changes in thinking around paramedic mental health (MHCC & PSHSA, 2015; Paramedic Chiefs of Canada, 2014). In 2016, *Bill 163 – Supporting Ontario’s First Responders Act* (2016) was passed by the Legislative Assembly of Ontario, to include the presumption that diagnoses of Post-Traumatic

Stress Disorder (PTSD) in first responders are work-related, and thus providing workplace compensation benefits. Additionally, in 2018 a new (voluntary) psychological health and safety standard, commissioned by the Paramedic Association of Canada, developed by the CSA Group was released through the Ontario Ministry of Labour for paramedics offering “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” (CSA Group, 2018, p. 6). As paramedic services determine whether or not they will implement the standard, or the ways in which they will implement it, there is still significant change under way in how this standard or any other mental health supports for paramedics are being or will be implemented.

4.3 Training of paramedics

In this section, I outline the training requirements for paramedics to practice in Ontario and the scope of paramedics providing prehospital care. The following section will discuss paramedics’ evolving scope of practice in the community.

4.3.1 Paramedic training in Ontario

To practice as a paramedic in Ontario, one must have successfully completed a paramedic program at the college level (or have qualifications otherwise approved by the Medical Director) (Ambulance Act, 1990). Paramedic training in Ontario is provincially standardized by the Ministry of Training, Colleges and Universities for Primary Care Paramedics (PCPs) as well as Advanced Care Paramedics (ACPs), meaning that there is uniformity among college paramedic program requirements across the province. College paramedic programs for PCPs are most commonly two years in length (OPA, 2018) and training includes in-class didactic, hands-on skills courses, physical fitness and lifting training as well as clinical components (both in hospital and on the road – in ambulance) (Ontario Colleges, 2018). ACPs receive an additional one year of training including in-class didactic as well as clinical training. Critical Care Paramedics (CCPs) have five years of additional training by Ornge beyond PCP training with a greatly expanded scope of practice and intensified training (Ontario Paramedic Association, 2018). As discussed in Chapter 3, in some countries, paramedics are trained at the university level versus the college level as in the case of Ontario. Health care training in other areas is

carried out at both university and college levels depending on the field, such as: medicine (MOHLTC, 2019) and nursing (College of Nurses of Ontario, 2019) at the university level; or registered practical nurses (Registered Practical Nurses Association of Ontario, 2019) or respiratory therapists (College of Respiratory Therapists of Ontario, 2019) at the college level.

4.3.2 The scope of practice of paramedics

Paramedics respond to high acuity, emergent, and life-threatening situations in the community (Bigham, Kennedy, Drennan & Morrison, 2013; Tavares, Bowles & Donelon, 2016). The community includes non-clinical, prehospital settings, in public as well as private settings such as people's homes. Their practice involves use of medical knowledge and training to carry out medical procedures and pharmaceutical intervention in community settings and "on the street" (Corman, 2017). Paramedics are an integral part of the current health system and treat and/or transport approximately 2 million patients per year across Canada (Corman, 2017). While traditionally paramedics are trained to provide acute medical or trauma care, increasingly this has included more complex care for chronic conditions, as well as lower acuity calls (Bigham et al., 2013; Tavares et al., 2016, Tavares et al., 2017), with many individuals not requiring emergency care, and as many as 50% of patients transported to emergency department (ED) discharged without significant treatment or referral (Bigham et al., 2013).

The role of paramedics is to provide emergency medical care to individuals in a variety of settings in the community. Their practice is dynamic, with multiple elements at play on different calls, and at different points in time. To describe the specific functions and responsibilities and depict the complex, multifaceted nature of paramedic work, Tavares et al., (2016) present a framework to describe the six roles of paramedics in Canada. The first is 'clinician,' providing safe and effective clinical care; second is 'team member,' working in an interprofessional setting in healthcare in collaborative health networks; third is 'health and social advocate,' addressing a patient's health needs while incorporating their social context and acting on the social elements of patient care if equipped to do so; fourth is 'educator,' carrying out health promotion and education when interacting with patients; fifth is 'reflective practitioner,' working as an autonomous practitioner, required to be reflective of one's practice to integrate past experience and enhance patient care; and sixth is 'professional,' with an obligation to work ethically, morally, and with integrity in the community, along with engaging further in research

and professional development. This final piece around professional development and role within the community ties into discussions of paramedic care provision in all domains of care and obligations to further education and practice. These roles of the paramedic highlight an obligation to continue to maintain a high level of practice and also to provide appropriate care in multiple domains, a piece that will be drawn on in exploring paramedics roles and obligations in managing mental health and psychosocial calls.

There are three main levels of qualification for paramedic work in Ontario; Primary Care Paramedic (PCP), Advanced Care Paramedic (ACP), and Critical Care Paramedic (CCP) (Schedules of Ontario Regulation 257/00, MOHLTC, 2018e). Additionally, there is a designation of Primary Care Paramedic Intravenous Autonomous (PCP IV Autonomous) for PCPs permitted to obtain peripheral IV access (MOHLTC, 2018e).

The majority of the province's paramedic workers are PCPs (79%) with significantly fewer ACPs (20%) with numbers variable by region, many regions having none. CCPs (1% of Ontario paramedics) work primarily for Ornge, Ontario's Air Ambulance provider (MOHLTC, 2018g) working mainly at the level of intensive care transfers with fewer than 20 CCPs employed by Toronto Paramedic Services (OPA, 2018). PCPs are able to administer a variety of medications, some life-saving (ie: epinephrine for anaphylaxis or severe asthma exacerbation) as well as symptom relief medications (ie: relief of symptoms such as nausea/vomiting or non-narcotic analgesics for pain). Additionally, PCPs are able to provide defibrillation in cardiac arrests along with airway management. ACPs have this same skillset however can provide additional medications such as cardiac drugs used to manage cardiac arrhythmias, narcotic pain management and sedation and can also provide advanced airway management with intubation. ACPs are also trained in intravenous (IV) therapy for fluid replacement and drug administration, something some PCPs in the province are also trained to do. CCPs have a substantially expanded scope of practice with skillsets including knowledge of and ability to read a wide variety of lab results, x-rays etc., and management of a variety of technologies, commonly used on longer transports such as by air. As noted above, PCPs are the most common level of qualification of paramedics in Ontario, and findings within Ontario indicate that the vast majority of calls provincially involve basic life support skills that PCPs are able to carry out, with somewhere between 2-15% of calls involving advanced care skills (MOHLTC, 2013). The

following table outlines the basic skillsets of each of the three main types of paramedic in Ontario.

Figure 4.2. Paramedic levels of care in Ontario

| |
|---|
| Primary Care Paramedic |
| 1. Medication administration of glucagon, oral glucose, nitroglycerin, epinephrine, salbutamol and ASA (80mg form). |
| 2. Semi-automated external cardiac defibrillation. |
| Advanced Care Paramedic |
| 1. Medication administration of same drugs as PCP, in addition to other drugs approved by the Medical Director – eg. Cardiac drugs, narcotic pain management and sedation |
| 2. Semi-automated external cardiac defibrillation. |
| 3. Peripheral intravenous therapy. |
| 4. Endotracheal intubation. |
| 5. Non-automated external cardiac defibrillation and monitoring. |
| Critical Care Paramedic |
| 1. Medication administration of same drugs as ACP, in addition to other drugs approved by the Medical Director |
| 2. Items 2-5 included in the ACP scope of practice |
| 3. Non-automated external cardiac defibrillation, electrical cardioversion and pacing. |
| 4. Maintenance and monitoring of arterial and central venous catheters. |
| 5. Gastric intubation and suction. |
| 6. Ventilation (mechanical) and setting of ventilatory parameters. |
| 7. Lab blood value interpretation. |
| 8. Management of chest tubes and chest drainage systems. |
| 9. Chest x-ray interpretation. |
| 10. Urinary catheter insertion. |
| 11. Intravenous blood product administration. |
| 12. Doppler flow monitor use. |

(MOHLTC, 2018e)

Further to the skillsets laid out above, there are other medications paramedics can administer and different skillsets paramedics can perform, variable by paramedic service. Different medications

include administration of naloxone for opioid overdose for example, as well as diphenhydramine (Benadryl) for allergic reactions, dimenhydrinate (Gravol) for nausea vomiting, and non-narcotic pain management such as ibuprofen (Advil), acetaminophen (Tylenol) or ketorolac (Tordol). In many services, these skills fall into the PCP or PCP IV skillset (MOHLTC, 2018a).

All qualified paramedics in Ontario are trained to provide a standard of care for an extensive variety of patient presentations and conditions including but not limited to: medical conditions involving abdominal pain, chest pain, shortness of breath, dizziness, stroke, syncope, seizures, toxicological emergencies as well as trauma including, extremity injuries, blunt or penetrating injuries, head injuries, burns, cold injuries and additionally obstetrical, pregnancy-related emergencies (MOHLTC, 2018b). Through the provincial guidelines for these different conditions, there is a baseline uniformity in the practice of paramedics at all levels of care, and a benchmark at which all levels of practice can be evaluated. These guidelines are ‘evidence-based practice’ guidelines, informed by research and implemented provincially and through Base Hospitals. This aims to ensure a continually evolving and most current, high level of patient care (MOHLTC, 2018b). While all guidelines are intended to be informed by research and evidence, in the case of mental health and psychosocial calls, it seems there may be less attention and focus on these areas and thus less evolved and informed practice – a theme that will be explored throughout this dissertation.

4.4 Evolving profession and practice: Community paramedicine and beyond

As the demands on the health care system have evolved such as increased demand for emergency care services, leading to higher ambulance utilization, ED ‘overcrowding’ and increased pressures on hospitals (Lowthian et al., 2011), the scope of paramedics’ practice and paramedics’ roles have rapidly expanded (Bigham et al., 2013). Posited reasons for increased demand of emergency health care services include population growth and ageing, changes in social support, accessibility of health services and cost (in some countries and settings), reduced access to traditional primary care services, an increase in health awareness and changes to community expectations (Lowthian et al., 2011). Paramedics are being requested to work as part of the ‘solution’ to health care crises, such as increased wait times in hospital settings and increased costs of providing health care (Corman, 2017). For example, paramedics internationally and in Canada have begun playing a role in maintaining emergency department

services in rural and isolated communities (O’Meara et al., 2012), and there have been advancements in paramedics providing treatment for minor or chronic health conditions without transport to ED, and referral to non-ED services (Bigham et al., 2013). Paramedics have been identified as being “well-positioned to recognized unmet needs of community-dwelling individuals and participate in efforts to avoid unnecessary ED visits” (Verma et al., 2018, p. 379). This shift has involved movement of paramedics into settings other than emergency 9-1-1 response care on ambulance, such as to under-serviced areas, and positions in long-term care settings, primary and/or family health teams. This type of care is not a response to 9-1-1 emergencies, as paramedics have traditionally practiced, but rather formal positions or planned visits in non-emergency settings and different roles and types of service provisions not on ambulance. The term “community paramedicine” is used to describe the range of programs deploying paramedics in expanded roles, programs that continue to increase (Verma et al., 2018). Filling these contemporary roles has been beneficial in reducing transports to ED (Tavares et al., 2016), however there is an ongoing need for assessment of the efficacy of such services (Bigham et al., 2013). There is also a need to consider what other gaps in the health, mental health, and social services care systems may be masked by paramedics filling such roles.

Examples of community paramedicine programs in Ontario include paramedic-initiated home care referrals to social and community services through local Community Care Access Centres (CCAC) (Verma et al., 2018), non-emergency in-home care for complex, chronic conditions (New Brunswick Health Council, 2016), home visits for seniors at risk of losing independence, routine blood pressure and blood glucose tests for those without regular access to services (News Ontario, 2017), and remote patient monitoring for those with congestive heart failure, diabetes or chronic obstructive pulmonary disease using technology to recognize exacerbations remotely (City of Guelph, 2017).

4.5 What constitutes mental health and psychosocial work in paramedicine?

In the following sections, I outline the limited academic literature that defines mental health work in paramedicine and compare this to how front-line paramedics in Ontario define and delimit their work. According to the frontlines, ‘psychosocial calls’ are not delimited from mental health calls’ but rather are often understood as constitutive of them. Drawing from interviews with front-line paramedics, management, directors, Base Hospital physicians as well

as paramedicine educators, I will present findings about what paramedics understand as mental health care work, as well as the extent to which they discuss and acknowledge the social and economic contexts as well as individual circumstances impacting mental health. I will then outline how important a SDOH context is for paramedicine and other mental health and social policy fields to move beyond a simple diagnostic label for defining and understanding mental health calls. I discuss the limitations to imposing a narrow definition to paramedic calls that are addressing mental health needs as well as the rationale for a broader, inclusive definition. I argue this understanding has implications for practice and policy across multiple domains.

The definition of what constitutes a mental health or psychosocial call to paramedic services -- as distinct from a call for physical health needs -- has received very limited attention in academic studies conducted across Canada, U.K., U.S.A., and Australia. The parameters of 'mental health calls' have been quantitatively documented, such as the frequency and predictability of calls (Clark et al., 1999; Cuddeback et al., 2010; Roggenkamp, Andrew, Nehme, Cox & Smith, 2018), and the clinical judgment and decision making skills required to perform the work (Parsons & O'Brien, 2011; Shaban, 2005a, 2005b, 2006), including social and/or psychosocial skills (Brady, 2012; Campbell & Rasmussen, 2012). Mental health calls include those with a chief complaint of a mental health need, including but not limited to suicidal ideation or attempts, co-morbid mental and physical health issues, and substance use issues (Cuddeback et al., 2010; Hawley, Singhal, Roberts, Atkinson, & Whelan, 2011; Prener & Lincoln, 2015; Wise-Harris et al., 2016). Cuddeback and colleagues (2010) argue that grouping 'severe mental illness,' alongside obsessive-compulsive disorder or general anxiety disorder makes for too broad a definition of a mental disorder. Whereas Brady (2012) presents a 'holistic' description of psychosocial care in paramedicine referring to looking beyond the physical health needs of patients to their psychological and sociological needs. It has been argued by Brady (2012) and others (Campbell & Rasmussen, 2012; Ford-Jones & Chaufan, 2017) that there are both social and psychological elements embedded in many calls, warranting further exploration and leading to a broader description of what might be a 'mental health call' for paramedics.

In terms of quantitatively estimating 'psych calls' within a U.S. study of an Emergency Medical Service, Prener & Lincoln (2015) note the challenge of estimating call numbers if only those with a mental health diagnosis as the chief complaint are identified in the data. They state that almost one third of individuals seen in the ED for behavioural, mental illness or substance

use issues arrive by ambulance. This number is likely a significant under-estimation as these issues pertain to many other individuals in the ED who arrive by ambulance, but whose chief complaint is not a psychiatric diagnosis, for example when a medical emergency or trauma might be secondary to a substance use issue (Prener & Lincoln, 2015). The challenge with quantifying these calls sheds further light on the challenges of arriving at one sole definition of a mental health call.

4.6 Parameters of mental health calls

Multiple types of calls were classified by paramedics as falling into the category of ‘a mental health call.’ Many paramedics and members of management in paramedic services stated it was challenging to arrive at one description of a call as it could be multi-faceted and involve a wide spectrum of issues.

One member of management in a paramedic service described their attempts to identify ‘mental health calls’ in relation to a program they were attempting to put in place to enhance resources for mental health calls:

Well, I think that’s ... I would say that a mental health call is ... it could be considered as an umbrella term, it’s very generic in a sense when you look at the documentation of the Electronic Patient Care Report because you can have anything but that’s coded in there from someone with cognitive impairments because of dementia, to someone who’s had a crisis, to someone who is in acute psychosis, so ... or even alcohol intoxication or drug overdose. So that’s one thing that I was trying to better understand and how to better define it because it’s really challenging when you’re looking at paramedic call volumes and you’re restricted to only specific code, primary problem or problem codes to really understand how it’s impacting your service ...

(Manager in an Ontario paramedic service, Interview 32, 2018)

Along with recognizing the challenges of defining this call type, a member of management identified the following issues: how important it is to understand which calls are mental health calls; the impacts on the workload of their service; how the service can better support individuals making these calls; and how the paramedics can optimally manage these calls.

When asked what comes to mind when thinking of ‘a mental health call,’ many paramedics provided responses similar to that of the definitions addressed in the literature: calls involving an individual with a particular mental health diagnosis, thoughts of self-harm or suicide, or those who have self-harmed or attempted suicide, as well as substance use calls. Paramedics stated that there was a very wide range of issues that could fall under the category of a ‘mental health call,’ acknowledging that this made it hard to provide a distinct definition. Beyond the range of mental health conditions, self-harm and substance use, paramedics spoke of mental health calls where they felt that individuals’ living and working conditions were strongly connected to their mental health needs and to the reason for the call. These included calls where the person lacked social support, a support network, and as not knowing where else to turn. Additionally, paramedics discussed calls that were received as medical or low acuity in nature, but then found on arrival to have a mental health component to the call. Finally, paramedics spoke of the patients’ age ranges for these types of calls. Below, in discussing ‘a mental health call,’ I will describe the nature of these different call types based on interviews and observations with members of paramedic services in Ontario.

4.6.1 Mental health conditions or diagnoses

One paramedic spoke for many when they outlined the following definition:

Mental health calls cover such a wide range. Like there’s something as, I don’t want to use the word simple, but I’ll just use it for an example, say as simple as somebody who wants to hurt themselves or wants to end their life, but doesn’t have a plan, they just want to talk to somebody. So they call 9-1-1, knowing that we’re trained professionals who would be able to help them get them in touch with the counsellors or the psychiatrists at the hospital who will give them a clearer picture. That ranges from people who actually physically harming themselves or have attempted suicide or it ranges from people who have ongoing conditions like bipolar disorder or depression or schizophrenia who are not compliant with their medications and are experiencing complications as a result of not taking those medications. So it can be pretty much anything.

(Front-line paramedic: Interview 030, 2018)

Paramedics attend calls for patients with mental health conditions or diagnoses -- including anxiety, depression, bipolar disorder, schizophrenia or generally psychosis – as well as less common conditions such as excited delirium or severe agitation with delirium, often presenting with combativeness, aggression, rapid breathing, sweating, high temperature, unusual strength and often associated with drug use (Vilke, Bozeman, Dawes, DeMers, & Wilson, 2012). During interviews, paramedics described how they also attend calls for various forms of psychosis, chronic depression or those experiencing a temporary episode of depression, as well as anxiety ranging from generalized anxiety to severe panic. As one paramedic noted:

It's the gamut, it's that anxiety attack, all the way to...excited delirium...the schizophrenic that hasn't had meds in three months...It's...the depressed suicidal ideation person.

(Front-line paramedic: Interview 001, 2017)

Oh...uh, the whole gamut. From, people who do have diagnosed...schizophrenia or multi-personality disorders... we deal with people with...the whole spectrum of the Asperger's syndromes and ADHD...we speak...we can deal with people who have... either acute or chronic depression states... the acute state is quite frequent...

(Front-line paramedic: Interview 005, 2017)

Paramedics provided examples of interacting frequently and repeatedly with “regulars” with chronic mental health issues:

I do a lot of people who are suffering from...a number of mental health things, whether it's...I have a regular that I pick up...probably once a shift at exactly three in the morning. I know when the call's coming out and I know exactly who it is. He's battling schizophrenia, um, delusions of grandeur... I have...I have a few other ones. I have a number of regulars, that I, I know when I'm going to pick them up and they all suffer from different...different pathologies...

(Front-line paramedic: Interview 002, 2017)

4.6.2 Substance use and addictions

A frequent call for paramedics are for those experiencing substance use, addictions and overdoses. Paramedics consistently included these in the category of ‘mental health calls,’

although some acknowledged that everyone might not identify these calls as such. Reference to substance use included alcohol use, illegal drug use such as methamphetamines – “crystal meth,” marijuana, narcotics including fentanyl and heroin, as well as overdoses of prescription or over-the-counter medications such as Tylenol.

We deal with plenty of, of people who have mental health issues. They're not typically calling because of mental health issues, they're calling because they're sick from... illegal drug use habits or whatever, but now while you're trying to treat them on that, you're still dealing with a mental health...situation.

(Front-line paramedic: Interview 005, 2017)

During the observation shifts I attended calls to individuals who were intoxicated from alcohol and other substances. One of these calls was not specifically for the alcohol intoxication; however, it was clear it was playing a role in the call as the individual had sustained an injury, breaking a window while intoxicated and upset. The other was an individual lying on the ground midday, intoxicated with members of the public waving down the passing ambulance, unsure of what was wrong with the patient (Field notes, 2017). Additionally, we encountered an individual who stated he was high on “crystal meth.” The individual said he was not sure if he'd had some of the “good” or the “bad” meth. The use of methamphetamines was not the primary reason for the call, however it was related to a complex domestic situation on scene (Field notes, 2017). Through interviews and observation, I found that when substance use is involved -- even if not the primary reason for the call -- it frequently impacts the medical, traumatic or psychosocial situation on the call.

4.6.3 Self-harm and suicide

Paramedics consistently included self-harm, suicide and attempts at both within mental health. Paramedics spoke of calls where attempts at self-harm appeared to them as more of a “cry for help,” rather than an active attempt at suicide. In all cases however, these were referred to as mental health-related calls.

And they just, think they've had enough and they wanna end it...Quite a few calls we've been to, people have legitimately tried and failed, and some they say they've tried but it's just...it's just a cry for help is what I see it as. You know, like you use a

Bic razor to, scratch your arm or whatever (scratching sound). Like you're not gonna die from that, but you made us come, you made the police come. So they're... whether they realize it or not, they're... I see it as they're looking for help, or asking for help...

(Front-line paramedic: Interview 009, 2018)

Paramedics spoke of how many of these individuals were not actively intentional with their self-harm but that these are people in distress who need to talk to someone. Even if the self-harm has done little physical damage, the activation of 9-1-1 for paramedic services is one step toward that individual obtaining help.

4.6.4 Living and working conditions as determinants of mental health

When speaking to paramedics, I asked about their understanding of what was a 'mental health' or 'psychosocial call,' as well as their experiences and their perceptions of what was driving so many of the mental health and psychosocial calls. I was interested in how and to what extent their dialogue about mental health calls focused on individuals -- 'people with mental illness' -- or on the complex conditions impacting their mental health? Based on my working experience as a frontline paramedic, as well as the literature I reviewed, I hypothesized that they would discuss a range of factors extending beyond 'mental illness' and include their perspectives from working inside people's homes during personal circumstances of emergencies and crises.

Before beginning, I was aware that terminology such as 'the social determinants of health' might be unfamiliar to many paramedics, but I also discovered 'psychosocial calls' was unfamiliar. I asked about the factors paramedics encountered during their work on the scene of mental health calls that contributed to activating paramedic services and then increasing people's distress. Many paramedics referred quite specifically to attending calls where they felt that living and working conditions were significantly impacting individuals' mental health and the reason for the call. The responses were rarely straight-forward, and were often multi-faceted. They spoke to a range of determinants of mental health. This included income and poverty, neighbourhoods, housing and food insecurity, social isolation and support, as well as experiences of discrimination. In these descriptions, paramedics were generally not referring to particular mental health diagnoses, but to the broader contexts that seemed to create distress and, in some cases, lead to crisis.

4.6.4.(a) *Income and poverty*

Issues stemming from low income and poverty were often the first factors to which paramedics referred. These issues were also a central focus of their discussions about what creates or contributes to distress for people who call for an ambulance. One paramedic spoke for many when they said the following:

Poverty. Yeah, poverty is a big one. It's tough to, you know, feel mentally strong when you don't have enough money for food and...right? And then you start to throw addictions into there and, things just really start to spiral yeah. You know, people will be living in, around here we find people living in old farm houses out in the country without a car, without a way to go get groceries, you know, would you feel happy about yourself in those circumstances, right? So it's all just a big, it's all just kind of a big circle, 'cause they've ended up in those circumstances because they're not able to hold down a job because of mental illness and, and how are you gonna feel better and get out of that cycle? When you've got eight hundred bucks a month or whatever it is for disability right now (*laughs*)

(Front-line paramedic: Interview 010, 2018)

Paramedics spoke not only of the distress caused by issues of income and poverty but that even reaching a point of crisis and requiring support from paramedic services, the cost of these services often presented as a barrier or further impediment to seeking and receiving support.

When I think mental health calls, I picture a wide range of anxiety, anxious people, people who are down on their luck, depressed, possibly suicidal. Mental health encompasses a lot of things. It's not just what you typically see as depressed. It can be just dishevelled-looking or poor health and living conditions. It comes in many shapes and forms. I've noticed it's usually a lot of financial issues with those calls and when we get called, if it's not from a facility and it's just for a personal home, they mostly don't want to go because of the ambulance fee, which we might not think of it as a lot, but for people who don't work much or who depend on government funding, it's going to be tough for them to put that ambulance bill in the budget. So, a lot of times financial issues are a big problem. And sometimes I think it's a social problem also. They don't want to go get help because they think that no-one's going to notice, no-one's going to care, no-one's out for them, no-one's going to know that they are getting help or they need help

(Front-line paramedic: Interview 027, 2018)

The cost of an ambulance trip in Ontario is \$45.00 if ‘medically necessary,’ or \$240.00 if deemed by a physician to be ‘medically unnecessary.’ There are certain exemptions to the fees for a ‘medically necessary’ trip if the individual receives several different types of government social assistance such as Ontario Works, Ontario Disability Support Program, as well as transfers between facilities (MOHLTC, 2012). As noted by the paramedic, this fee may be a substantial personal cost when money is a significant concern.

Another paramedic spoke of the impact of poverty on individuals’ distress and paramedics’ sense of helplessness in seeing unresolved distress. They spoke of recognizing poverty and its related challenges and locating it as largely outside of patients’ as well as their own control – there’s nothing one can do about it and it’s something patients can’t just “fix.”

I’m gonna say lack of money or welfare issues is like the biggest thing so then...and maybe it’s more distressing for paramedics sometimes to see the, lack of child care or the...what the children are living in, like that, that atmosphere, and, and...whether it’s a money thing or a mental health thing or a drug addiction or...you do see those right, where it’s...and obviously, lack of money as you know leads to all kinds of healthcare issues right. Causes a whole string of outward problems that you see...you walk into the house, you, lots of times you just shrug your shoulders and keep walking right? Because you know that there’s nothing you can really do about it, or think you can do about it. So, it’s, it’s there...again, it, it’s...yeah...generally it’s a money thing. And whether that money stems from them being on the welfare system, or unemployment, or drug addiction or whatever right? There’s usually a cause for it, but...It’s something bigger than most people can fix.

(Front-line paramedic: Interview 008, 2018)

4.6.4 (b) Neighbourhoods, housing and food insecurity

Many of the calls to which we responded while I was observing were in what appeared to be low-income areas, and paramedics often described them as such. The living circumstances associated with poverty and low-income were apparent on many calls, and it was interesting to hear paramedics further highlighting this in their interviews. There were a range of circumstances related to living conditions that paramedics identified contributing to distress.

I mean a lot of the times when you go to these houses or places or whatever, I mean there's some of these people who don't have a home right? You're going to the missions, or the whatever places that these people live in and now, and yeah, you can see that, you know, just the way they're living or whatever's happened in their life has definitely impacted as to how they think. I mean, you know, you go to other places and, and you know it's filthy, there's no furniture, or...you know whatever. And you've gotta think for sure that, they're living off of hardly any money. Well. How do you have a really good state of mind when you don't have the proper necessities to...to live.

(Front-line paramedic: Interview 007, 2017)

Paramedics in both more rural and urban paramedic services identified mental health calls for individuals who are homeless or in precarious living situations, and a general lack of community support for these individuals. They stated that for many of these individuals they either do not have a support network, or it is not working for them. They identified these calls as mental health-related calls and also suggested that sometimes they were more of a wellbeing check for some individuals where other community supports may be lacking. Descriptions of these types of calls were frequent in the urban setting but also in the more rural setting in small towns.

One paramedic from a rural paramedic service discussed individuals who are homeless, stating:

And of course most of homeless people have some mental health issues. So it's good to know their names and stuff like that and you can respond to them one on one type thing...some... people out in the community just don't know how to react to that kind of thing. So they call the cops or they call us... Usually it's just a welfare check to make sure they're fine and they're warm, especially in the winter time. Let them know there's places to go at night if they need to.

(Front-line paramedic: Interview 015, 2018)

Along with issues of precarious living and homelessness, paramedics spoke about the home lives of the people in crisis, and there being no food in the fridge, as well as general food insecurity on a day to day basis for people, children or older adults, in particular. In discussing some of the

ways one paramedic service supports people in the community deal with particularly challenging living conditions, he speaks to some of the circumstances seen on these calls.

We find a lot of the elderly, you get into their homes and they don't have any food. Or, they've got that rotten roast beef in the fridge, or whatever, with maggots on it. And, they {paramedics} turn around and they know that these people need food, so, we'll provide a food voucher, or we'll have the medics go and actually purchase the food and take it back to the house for them. We cover that. We are also covering taxi vouchers from the hospitals. A lot of times the family can't make it in, or, they can't get back from the emergency situation, cause, either they've forgotten money, or the way the situation has occurred. Then, we cover the cost for them to be taken back home, or brought into the hospital for their family members.

(Manager in an Ontario paramedic service: Interview 033, 2018)

While this paramedic is talking about providing supports to individuals in these circumstances, this is far from the norm in paramedic services nor is it considered a formal program in place in most services.

Paramedics spoke of the hygiene condition of the places in which people live and how such conditions impact people's distress. The example of bed bugs was identified in my field notes from an observation with one urban paramedic crew.

As my crew rolled our stretcher down the hall toward where they would clean it, they pointed out a crew who was waiting close to the ambulance entrance with an empty stretcher. They said, that crew just came in with a patient who was covered in bed bugs and the patient's being decontaminated in the showers before they're brought into the actual emerg department – that's what we do. They said there are loads of buildings in {name of city} with big bed bug issues. They said apparently the building the person came from has been fumigated for bed bugs every two weeks for the last two years and they keep coming back. My crew went on to tell me that a couple of weeks ago they did a call where they were called by the bed bug cleaning company who called 9-1-1 because they were called in to clean but found a person lying on the floor. They said the cleaners were kind enough to wait for the medics to arrive and cleaned their boots and equipment for them as they left. As they told the story they made it clear that bed bugs are a very regular thing for them to encounter on calls.

(Field notes, 2017)

At this observation, the other crew asked questions about the study. On learning about it, one paramedic rolled his eyes and said, “Oh boy, this call was *all* mental health.”

Alongside little income and precarious housing, bedbugs cause an immense degree of distress in any circumstance. Paramedics often speak with immense loathing for “bed bug calls,” the process of decontamination following the call, and the knowledge that you could bring this problem into your own home if it is not dealt with properly. It reflects, even if not overtly, an understanding of the immense disruption and upset that this has on someone’s living circumstances. As another medic stated previously, “How do you have a really good state of mind when you don’t have the proper necessities to...to live?” (Front-line paramedic: Interview 007, 2017).

Beyond individual living circumstances, paramedics frequently spoke of a higher volume of calls (and often specifically mental health related calls) in certain neighbourhoods and these are inevitably lower-income neighbourhoods. I asked paramedics about call volumes after an observation.

After the call as {paramedic} was finishing paperwork, I helped bring the stretcher out to the ambulance with {paramedic partner} and we were chatting a bit. I tried to inquire a bit more about some of the SDOH elements of the research. I asked, given the downtown location of their station, whether a significant portion of their calls is what you might call “lower income” areas, {paramedic} said, “Oh yeah” with emphasis, “absolutely.” She said, not even just downtown, different parts of the city. She said when she worked in one end of the city, she did all calls where people averaged maybe 50-65, lots of COPD, certain types of illness. Then she worked in the other end of the city (suggesting the affluent end of the city) and she said the average age on calls was all 75-80. She said, “I didn’t realize you could have a whole extra 10-15 years to live if you live in the right place.” This statement seemed to sum up so well the SDOH.

(Field Notes, 2017)

While she was not referring exclusively to mental health but more so health and longevity of life in general, this observation was a powerful and apt summary of the impact of living conditions, the social determinants of physical and mental health.

4.6.4 (c) *Social isolation and support*

Another context frequently discussed was the impact of significant social isolation and a lack of social support identified by paramedics to be leading to mental health or psychosocial calls. One manager in a paramedic service discussed a lack of support identified by paramedics as impacting individuals in mental health crisis as well as the lack of support in their day to day activities when they require assistance:

So it's just we get to see those people in those times in crisis or we get to see those people who are failing to thrive and don't necessarily have those family supports. They lack those social supports to continue on or – well they can continue on but they're just scraping by; and then develop maybe a reliance on 9-1-1 systems. We're working – but that's kind of where...the people who aren't like an acute – like you said, those emergencies per say but they're calling us with mobility issues. We had one patient that was calling us like multiple times a day to help transfer, to get up off the commode and things like that. That's an inappropriate use of 9-1-1 services but what is that patient to do because they don't have any other services in place does and didn't know about them.

(Manager in an Ontario paramedic service: Interview 034, 2018)

When referring to a lack of support at the individual or personal level, paramedics spoke of people who were in distress because they lacked family, friends or other social support and contact. These examples included the elderly, those who are homeless or in precarious living situations, and other marginalized members of society often experiencing loneliness and isolation. They referred to calls where this lack of support led to a point of crisis, as well as calls where individuals primarily wanted company or temporary support from paramedics.

Respondent 016-We've done a lot of people that just want, to have us to come over, talk ...I mean they call, they know the system, and they want to get us to come there ... but once we get there, they're just... They're just, oh this and this and this and it's not really...

Respondent 017-And especially the elderly

Respondent 016-Yeah, yeah, there's a lot of elderly that...

Respondent 017-Yeah

Respondent 016-The ones that are alone in their homes right.

(Group Interview with front-line paramedics: Interview 016 & 017, 2018)

Paramedics from urban, suburban, and rural services as well as both more northern and southern Ontario referred to loneliness and isolation as a significant driver of mental health distress and calls to paramedic services. They pointed out that while the types of isolation may be different in the city versus the country, it exists in both. Paramedics stated often they had the sense that people simply wanted some contact, someone to talk to. These two paramedics in a rural paramedic service further identified a general sense of loneliness and isolation experienced by many individuals with little to do in the community and little interaction to be had.

I've found as far as here, it's been more loneliness and isolation. Like they're really, a lot of the communities... there isn't a lot to do. There's not a mall that you can go to, or a movie theatre that you can go out to, like...It's very restricted. And especially kinda in those in between months where you might not be able to go out snowmobiling yet or it, it's still too cold to go quite fishing on the lake kind of thing. Then, a lot of people just get really... Sad

(Front-line paramedic: Interview 017, 2018)

Paramedics also spoke of individuals with histories of personal trauma such as abuse or loss of a loved one, which was causing either acute or persistent distress. This distress was either the main, or one of the main reasons for the individual's interaction with paramedic services as individuals were lacking support in managing those circumstances within their own support networks.

Lack of support services for caregivers often fell into the category of psychosocial calls and a circumstance leading to distress and calls to paramedic services.

I'd say places where people live alone or people live with a caregiver situation where it's just the patient and one caregiver are probably more likely to call and just be like "I have no support. I have no help." Or people that aren't in tune with – they haven't called for CCAC to come help or to get the homecare in that they need. Like those would definitely be factors that I'd say could cause us to be called.

(Front-line paramedic: Interview 031, 2018)

Paramedics spoke of the family of those with mental health needs as well as caregivers of different types. Caregivers included those who are a primary daily care provider for a family

member requiring ongoing care, as well as family supporting those with mental health needs. Ultimately, paramedics referred to these individuals as without support, resulting in distress and sometimes crisis, leading to activation of paramedic services when families on their own were unable to cope or manage without further support. They also discussed calls when they were on scene to address an acute physical health problem for a patient and realized they also had to manage the distress of a family member distraught by the situation.

A member of management in a rural-suburban paramedic service discussed the mental health challenges existent for care providers in their service:

And sometimes it's not the mental health of the patient that's the problem, it's the mental health of their caregivers that are unable to provide for them. And there's, you know, I don't think enough support out there for them to know what to do in those cases.

(Manager in an Ontario paramedic service: Interview 034, 2018)

The link between the lack of support for families and the context of the larger mental health system was also highlighted:

We have mental health patients who are just living with family but the family has no idea how to cope, so they have a built in system...they have a built in social system to support them, but because of that, the bigger mental health system doesn't, doesn't support them, "well you take care of them, they're living with you, so, so you deal with it."

(Front-line paramedic: Interview 003, 2017)

Support gaps such as in the larger mental health system and lacking community mental health supports were also identified as reasons for calls to paramedic services.

It's still, you know, there's a long, long waiting list, at least in our community, for psychiatric services, case management services, specialized care. And communities were not really a very welcoming place for people with mental illness – serious mental illness. So, lots of times I think emergency services get contacted because people are unsupported.

(Interview with paramedicine educator: Interview 039, 2018)

4.6.4 (d) Experiences of discrimination

Discussion of racism and discrimination was minimal, in fact there was really only one front-line paramedic who elaborated on the role that discrimination might play for people's mental health and daily experiences of distress. Rather than an isolated circumstance however, it was more likely that this paramedic happened to be one of a smaller number attuned to the issue. While there are no reported demographics of the ethno-racial backgrounds of paramedics in Ontario, the services with which I observed and the paramedics whom I interviewed were almost all white. One male paramedic was a visible minority. During an interview he noted that while the service described its paramedic mental health peer support team as 'diverse,' he observed that it was all white. There seemed to be an incongruence in even understanding what 'diverse' meant to the service (Interview 027, 2018). In addition, when I asked about the factors creating distress that paramedics see on calls, one paramedic found discrimination to be a profound and significant issue.

The other stuff where I'm talking about the multiculturalism...I think there's a big... (pause) the community is diverse here, but it's not really...the city as a whole isn't accepting of those populations, so what I find is...it's almost like...it's almost like what they have with the indigenous populations. It's almost like a cultural identity crisis. There isn't really that community for a lot of these little groups that kind of ...feel their own cultural beliefs or whatever, and there's some pressure related to that. So the aboriginal community that we have in the city, that tends to be one because the reserve's pretty close, but they want to get away from the reserves to come into the city. And then, they have that loss of identity or cultural identity and then they turn to drugs and stealing and alcohol and they're just not coping. We have a lot of Syrians that came here because we were a sanctuary city for a little bit. I feel like we go for a lot of calls that are anxiety and depression related but that culture doesn't really look at mental health in...it's not framed in the same way. And then there's a lot of...there's subvert racism that can play on people and that leads to...you know, social psycho-...like stressors realistically, to those populations.

(Front-line paramedic: Interview 002, 2017)

While not discussed by other front-line paramedics, a director of a Base Hospital spoke also of the importance and unique needs of the indigenous community and the very real causes of distress, a field in which he stated paramedics had little formal training but a community with

whom they interacted frequently and the mental health needs are specific to their cultural histories and current lived contexts.

I think that's important, you know, seeing more people with depression – and I'll go back to the indigenous population once again... I think that's an important thing in our areas. There's not a lot of education they have received on that, and again, with indigenous people it is different and their needs are different the resources are different. And how do you manage the patient, even in the prehospital care setting is somewhat different too.

(Base Hospital physician in Ontario: Interview 044, 2018)

4.6.5 Medical or mental health calls?

One other way that paramedics described mental health calls was to talk about how they originate as calls for acute physical health emergencies. Paramedics stated that it often seems patients call 9-1-1 with a physical health complaint when they primarily require help with their mental health, but are unsure of how to get it.

...We got called for a rectal bleed... We got there and the patient had 75 different medical complaints and we realized fairly quickly that it wasn't... that that wasn't necessarily her intention by calling us. We spoke with her about substance abuse and seeking some help for detox and talking to Crisis and working with them... For that specific call it was more so the patient was, I think the patient was trying to get to the hospital by going around the wrong means and was just making outlandish claims... It was sorting through her hurdles that was the most difficult of the call. I spent the whole time going to the hospital, talking about that stuff, and it had nothing to do with the call.

(Front-line paramedic: Interview 025, 2018)

Other paramedics noted the challenge of sorting through a variety of physical complaints that may have been part of the dispatch information, ultimately to determine that a mental health concern is what was driving the call.

Respondent 1: But generally I usually find that the calls for psychological crisis usually involve some sort of call from something else and you discover that it's related to a psychological crisis...

Respondent 2: Sometimes these calls come in as a medical and then when we reach the patients you find out that it's actually more of a mental health issue than it is an actually physical ailment but coming through as a physical ailment whether it's chest pains or shortness of breath, etcetera.

(Group interview with paramedicine educators: Interview 05 & 06 2018)

Sometimes paramedics referred to anxiety attacks that came in as shortness of breath and chest pain – a particular challenge as they must always consider a physical health emergency, even if it is suspected to be mental health related. Paramedics pointed out that they are not in the position to make mental health diagnoses, even if they suspect the issue to be psychological rather than physical, and that they must carefully investigate all possibilities – a challenge in a fast paced, acute care setting, often with limited information on scene.

A senior member of management in a paramedic service stated:

...the challenge paramedics face is knowing which ones are true mental health and which ones don't have some sort of organic root. So, being able to define, you know, a delirium from a psychiatric call is tough to do in the field without any sort of enhanced supports or any sort of enhanced training, which paramedics don't get at the college level.

(Manager in an Ontario paramedic service: Interview 034, 2018)

During my observation shifts, on several occasions, calls presented with a primary medical complaint; however, by the conclusion of the call, either the patient themselves identified that they had really just been feeling anxious or stressed, or the paramedic crew discussed after the call that they wondered about a significant mental health component to the call. One example was an older woman who had called 9-1-1 stating she was short of breath. The patient presented breathing rapidly and with a high blood pressure. During the call however the patient stated she was just so worried about her upcoming doctor's appointment, and by the end of the call, when we arrived at hospital, the patient's blood pressure and breathing had returned to normal (Field Notes, 2018). Two other calls occurred with patients complaining of severe headache and feeling unwell. Both patients had extensive mental health and personal trauma histories (including diagnoses of post-traumatic stress disorder). In all of these cases, the paramedics assessed and considered medical, organic causes for the complaints, and treated the

patient according to their presenting conditions and standards; however, in all of these cases, the paramedics stated that they felt there was at least some mental health component to the call.

4.6.6 Mental health calls and age

Paramedics described mental health calls by call types as well as circumstances, but also they described the different range of ages of individuals they encountered for mental health-related calls. They spoke of younger, school-aged children as well as teens and university-aged young adults. In speaking of youth, many paramedics stated that they have seen a surprising upswing in mental health related call volume for this population.

You know when you're dealing with kids. That one's hard, you know, cuz you think geez. How are you so young and having these weights on you, kind of thing? Or, just, thinking that you've got going on in your mind, kind of thing, that's...and it's just becoming more and more prevalent. Like, unless we just never talked about it and it was hidden away, but now it's out there all the time.

(Front-line paramedic: Interview 007, 2017)

In their discussion of mental health conditions and diagnoses in younger people, they also referred specifically to the social and economic contexts in which distress seems to be occurring.

I mean I know that there are some hereditary components in mental health. I get that the whole prefrontal cortex blah blah blah – For some kids that's true, but that same problem was there when I was a kid and we didn't have anywhere near as many mental health kid problems. So, you know, kids are undergoing tons more stress than we ever, than I ever went through as a kid. I never had to worry about where my next meal was coming from or did I have a home to sleep in or, you know. And that's happening, because things are – like there's less pay, there's less job security, there's less . . . But I'm not a politician.

(Front-line paramedic: Interview 023, 2018)

Adults of all ages were discussed by paramedics, while older adults and the elderly were specifically mentioned. Distress resulting from isolation and loneliness affected elderly people. Also, often paramedics referred to behaviours accompanying Alzheimer's disease and Dementias (Alzheimer's is in fact a neurological disease with biological basis, rather than a mental health

condition (National Institute on Aging, 2017), however this was often included as mental health-related by paramedics). Nearly a quarter of individuals I interviewed referred to Alzheimer's or Dementia when describing mental health-related calls.

...We pick up a lot of dementia patients, it's...kind of a form of mental illness...There's other things that are tied in with that...caregiver burnout, that's a big one that we kind of see, and it can exacerbate it, because maybe they're not getting their medications properly, or maybe they don't understand why this person is in their home that is being mean to them, because they've got, you know Alzheimer's or dementia or whatever, and then that patient's lashing out because of it.

(Front-line paramedic: Interview 002, 2018)

They either referred to it as a type of mental health-related condition, or referred to the psychosocial needs of patients or caregiver of those with Dementia or Alzheimer's that result in calls to paramedics.

We get a lot of elderly patients with spouses or children or whoever that are their caregivers who are just failure to cope. Like they can't be their caregiver anymore, they are on a list for homecare and long-term care and things like that, but it's not getting better. We have calls where people aren't sleeping and like "I've been following my mom, who has Alzheimer's, who is a risk to herself, around for the past four nights, because she won't sleep so now I'm not sleeping and I don't know what to do." We get a lot of that, like "Just take them to hospital, because I can't deal anymore." I would think that would probably be the most prevalent. Like this is not a medical situation necessarily, it's an exacerbation of a medical condition, but it's not an emergency, other than they cannot be cared for at home anymore.

(Front-line paramedic: Interview 031, 2018)

4.7 Derek¹: A mental health and addictions call in an Ontario city

In this section, I present an observation from a call conducted while with a paramedic service in a mid-sized Ontario city (sub-unit 1). The paramedic crew were Beth and Terry, two women who have worked as paramedics for over twenty years, and are regular partners working primarily in a city centre. Prior to this call, I had attended several other calls with this crew.

¹ The pseudonyms of all paramedics and patients are to protect confidentiality.

They were seasoned paramedics who I found to be adept at handling a variety of situations and interactions, including with people who may be considered aggressive or more challenging. They interacted with compassion and what appeared to be genuine consideration for each patient they encountered. On this particular day shift, Derek was the third person we attended.

We next got a call for to an “unknown” Code 4. The call details said “PD {police department} tiered, yelling in background, don’t want an ambulance.” They [the paramedics] noted this is a “bad area,” they said we would wait for PD before entering. We arrived on scene to what appeared to be a low income, low-rise apartment building. PD arrived on scene and were also trying to gain access and determine what was going on, however there was some delay to access as we tried to gain access to the building and determine who called.

(Field Notes, 2017)

The call details indicated some intensity to the situation. A Code 4 indicates that it is a high priority call, and the ambulance responds with lights and sirens. This dispatch information provided no details as to the nature of the issue on scene, but did advise paramedics of the potential for safety concerns. Ultimately however, we would not know what type of situation or concern we would be walking into until we actually arrived on scene.

Eventually we were met by a woman, found to be the sister of the patient in question. She was upset and indicating there was a dispute about her staying at the apartment with her brother {the patient} and mother, and that she had been trying to help them and now they weren’t wanting her to stay. She stated she has her own history of bipolar.

(Field Notes, 2017)

The call involved mental health and addictions. This interaction described above took place with both paramedics and police present in the stairwell of the apartment building while speaking to the patient’s sister, a woman who appeared to be in her late 20s or early 30s. She was initially upset and agitated, however, both paramedics and police spoke to her calmly, listened to her frustrations and advised that they would follow up with her family members in the apartment. While this individual was not the main focus or even the “patient” on the call, it was evident that she was struggling with mental health and in a certain level of distress, and it was

necessary to take the time to interact carefully with her in order to proceed with the rest of the people on scene. Upon leaving the discussion with the woman, she appeared somewhat more calm and was content for Beth, Terry and some of the police officers to proceed upstairs. She remained downstairs, away from the apartment.

Eventually we went up to the apartment (with police) where she indicated the mother and brother were. Police and medics alike were careful entering the apartment, standing to the side of the door as the door was opened. When the door opened, we could see a chair overturned, broken glass, and red liquid all over the wall. PD asked what the substance was, and the male patient stated it was juice as he had thrown the glass of juice at the wall.

(Field Notes, 2017)

As we entered the apartment, it was a striking scene, particularly with the wall covered in red – the police officer verified that it was juice as there was a juice glass broken on the floor. Both the police as well as the patient on scene had a laugh that they were glad it was just juice as it looked distinctly like blood. It was evident that the apartment was in disarray and poorly kept. In the apartment there was a young man in his early twenties we'll call Derek, and an older woman who claimed to be his mother, appearing to be in her fifties. Both Derek and his mother appeared somewhat unkempt. Derek was fidgety, intermittently pacing around the apartment and trying to clean up the juice and broken glass, and appeared to be somewhat agitated. When speaking to the police and paramedics however he presented as willing to speak and quite cooperative in his willingness to interact with them.

In discussion with the patient {Derek} and the patient's mother, they advised they just moved in here. The crew member {Terry} mentioned she realized they had just picked up the mother last week (the mother acknowledged this). The patient himself acknowledged he'd been doing meth, and there was a discussion about "good" and "bad" meth and which he might have come across.

(Field Notes, 2017)

The conversation between Derek, his mother, police and Beth and Terry went on for several minutes. Derek acknowledged that he was feeling agitated and needed some help. He acknowledged that he had gotten upset in the argument with his mother and sister and had

thrown and broken the glass. Beth and Terry advised Derek that they could take him down to the hospital to get some help. Derek was somewhat reluctant and while he would not commit to actually being transported to hospital, he agreed to come down to the ambulance to speak to them further and be assessed.

Eventually {Derek} the patient agreed to come down to the ambulance to be further assessed and possibly come to the hospital. {Derek} advised he had just got out of jail and hadn't been prescribed his medications since leaving prison. The crew tried to encourage him to come to the hospital where he could get his medications sorted out and talk to someone. He was reluctant and said he could just go to the clinic nearby with his mother and would get them sorted out there. They {Beth and Terry} talked for quite some time with him in the back of the ambulance, on scene, however ultimately he decided he did not want to go to hospital. He signed off on the computer, left the truck and went back into the apartment.

(Field Notes, 2017)

Beth and Terry were patient with Derek, encouraging him to come to the hospital to get some additional support, but allowing him time to make the decision for himself. During the time in the back of the truck, Derek became somewhat more agitated and quite adamant that he would not come to the hospital, and would get his medications and speak to someone by other means. Beth and Terry advised Derek that they would not force him to go to hospital (he denied any thoughts or intent to hurt himself or anyone else), and it was his decision, but they did encourage him to go. Ultimately, he decided to remain at home with his mother. Beth and Terry obtained a signature from him, confirming he would not come to hospital, and had some additional discussion regarding what his alternatives could be and advised that he could call them back if needed.

After Derek signed off and left the ambulance, Beth and Terry drove a little way away from the apartment building to work on some paperwork. We were discussing the call, particularly my interest in it as a mental health related call, and I asked them what some of the challenges are in managing these types of calls and how they feel about them.

They said what they really want to know is what is the actual outcome for patients going in to Emerg. They want more information for medics so medics really know what they're telling the patient. They said, they were encouraging this guy to come,

and trying to tell him about the help he'll get at the hospital, but honestly, they don't really know what kind of support he'll actually get there or what the process is at the hospital. They said it seems really doctor dependent. They were unclear what would happen for someone with a diagnosis and needing his prescription. We also discussed how it seemed odd that post-prison the patient had not been given follow-up for his MH {mental health} meds and support. They said it would be really helpful to know what services we (EMS/hospital) can actually offer and what they actually look like so they are providing accurate info. Even phone numbers for example. They said they want to feel we can honestly provide info to patients.

This was an interesting discussion with a highly experienced and seemingly thoughtful crew, and informative to know that even a crew such as this felt that they truly didn't have a clear picture of what the process looks like for mental health patients at hospital, what services are really offered. I thought that this seemed like an important piece to make note of, and potentially an important piece in a report back to paramedic services.

4.8 Discussion: Wide parameters defining mental health calls

Based on the findings above, in this section, I discuss the contextualized descriptions that paramedics offered when describing calls, and the importance of this context for defining 'mental health calls.' While paramedics did describe how on the one hand mental health calls involve particular conditions, diagnoses, self-harm, suicide and substance use, importantly, paramedics also frequently described the circumstances that create distress. Paramedics drew attention to the variety of circumstances not only at individual and family levels, but also at community, social, political and economic levels that escalated into distress, crisis and calls to paramedic services. Paramedics avoided a narrow definition of mental health needs as medical or individual problems, but located the problems at higher levels in society, such as income, neighbourhoods, social isolation and experiences of discrimination. Paramedics often did not discuss mental health calls as 'a call for someone with depression,' or 'a call for someone with anxiety,' but spoke extensively about the conditions and contexts creating mental health needs and labelled that as the 'mental health call' itself.

Paramedics avoided simply identifying a person with a mental health problem, but rather as a person lacking appropriate supports to sustain good mental health and wellbeing. They discussed a range of living and working conditions -- namely social determinants -- they found to be leading to distress and calls to paramedic services. Their discussion highlighted that those

who are socially and economically disadvantaged bear a disproportionate burden of mental distress (Patel, 2010). They identified many challenging conditions and determinants encountered by individuals, leading to poor mental health (Allen, Balfour, Bell & Marmot, 2014) and suggested that these circumstances are seen by paramedics addressing mental health and psychosocial calls.

Paramedics indicated that patients were calling 9-1-1 as they did not know where else to turn. This issue indicates tensions between the choice of the person in distress, seeking help, or having help sought for them. These ‘choices’ of where to turn are impacted by the structures and supports that exist or are missing in the mental health and social care systems. As a result, paramedic services provide support, even if temporary, where other supports are lacking. Highlighting the context and factors creating distress and leading to mental health calls speaks to a level of understanding, at least among some paramedics and paramedic services management, that mental health is not an individual problem, but one impacted by a range of circumstances and structures.

Feminist political economy highlights the importance of the role of daily lived experiences and context (Smith, 1989), as well as the context of both care providers and care recipients (Armstrong & Braedley, 2013). In their descriptions of mental health calls, paramedics drew attention to daily lived experience and the context of those receiving care. The SDOH approach to mental health in this dissertation draws our attention not simply to rates of ‘mental illness’ (Hankivsky & Christoffersen, 2008), but to the contexts impacting mental distress and also the resultant policy implications. In describing many of the circumstances of distress on calls, paramedics often presented it as a reasonable response to unreasonable circumstances.

Paramedics drew attention to the distress and lack of support existent for those living in poverty, with poor housing, employment and other living conditions. They identified these circumstances and the problematic nature of these conditions, rather than simply labeling and identifying disordered thinking and behaviours. This narrative around mental health and distress supports a shift away from reductionist understandings of mental health and accounts for people’s experiences of distress, and the circumstances surrounding distress. These contextual descriptions of mental health calls, minimize the pathologizing of people’s experiences and detract from biomedical focus on ‘mental illness’ supporting the critical mental health literature

as well as a SDOH approach to understanding and addressing mental health. The unique position of paramedics, entering people's homes and living environments (Brady, 2012; Ford-Jones & Chaufan, 2017; Tavares, Bowles & Donelon, 2016), offers insights into the living conditions in which distress and poor states of mental health exist, drawing attention to the relationship between health and social context.

4.9 Conclusion

This chapter serves as an introduction to paramedics' work and working conditions in Ontario. It provides an overview of paramedicine in Ontario, paramedics as care providers, paramedic training and the continued evolution of the profession's scope of practice and sites of care. Many of these areas will be expanded upon in subsequent chapters of the dissertation, however this chapter lays the groundwork for contextualizing mental health and psychosocial calls as they pertain to paramedics providing care. This chapter also serves as an introduction to mental health and psychosocial care work in paramedicine. As paramedics described many calls by their context and circumstances leading to distress the social, political, and economic circumstances were highlighted, such as those leading to loneliness and isolation, through to housing, employment and appropriate living conditions.

The perspectives of paramedics presented in this chapter offer a refined understanding of what 'mental health' and distress issues paramedics are encountering in the field. A broad and inclusive definition of a 'mental health call,' calls reflects distress experienced for a range of circumstances. The next chapter explores the policy guiding paramedic practice on these calls, and policy that may be impacting calls to paramedic services.

Chapter 5: Mental Health Calls in a Policy Context

5.0 Introduction

As outlined in Chapter 2, Ontario paramedics' work is guided by multiple policies and standards governed by individual paramedic services, Base Hospitals and provincially. Within these policies and standards, there are specific regulations guiding the practice of mental health or psychosocial care in the prehospital setting. Additionally, there are also a range of Ministry of Health and Long Term Care (MOHLTC) policies impacting the types and volume of mental health and psychosocial care provided by paramedic services along with a range of social policies related to the social determinants such as housing, income, employment, education and other social policy potentially impacting these calls. This chapter critically explores how policies and standards affect paramedic practice and calls for mental health and psychosocial needs. It also explores mental health policy, and the overarching neoliberal context that impacts mental health and social policy. Ultimately, the chapter discusses the ways in which shifts in policy may impact calls to paramedic services and paramedics as mental health care providers.

These mental health and social policy trends are analysed with a feminist political economy framework and a SDOH approach to provide context for issues such as call frequency including deinstitutionalization and the availability, accessibility and appropriateness of community mental health services. Deinstitutionalization of individuals with mental health diagnoses from hospitals and institutions into the community is discussed in terms of the shift in the site of mental health care and the resultant impact on paramedic and other front line services. Additionally, existent community mental health services, and the policies and ideologies which guide provision of these services are examined for the extent to which crises and paramedic activation occurs. A feminist political economy framework highlights the tensions between structure and agency such as how the care work performed by providers and received by those in need of care are related. I explore the tensions between standards that guide and constrain paramedic practice and community mental health supports in relation to individual paramedics' agency in providing care and the needs of individuals seeking care. These constraints include limited resources and guidelines for paramedics and providing mental health and psychosocial care and the limited 'choices' for those with mental health and psychosocial needs seeking support from paramedic services. I explore how social and economic policy and neoliberal ideologies, such as welfare state retrenchment and responsabilization of individuals for mental

health and care in the community impact the social determinants, including poor living circumstances and paramedic call volumes.

This chapter will begin by describing the policy that guides paramedic practice in mental health and psychosocial care and the policy impacting the transport of patients encountered by paramedics. The next section will explore the policy context that impacts the type and volume of calls received by paramedic services, and how neoliberal ideology influences and guides the policy context. I present paramedic perspectives on these policy areas and finally, I discuss the role of paramedic services in managing mental health and psychosocial emergencies, and question whether it is the most appropriate service to be providing this care.

5.1 Policies addressing management of mental health calls by paramedics

The overarching standards guiding paramedic practice in Ontario were outlined in Chapter 4. This section describes the mental health and psychosocial care paramedic standards; Ontario *Mental Health Act* (1990) stipulations for paramedic practice; and the *Ambulance Act* (1990) and its directives around the transportation and destination of patients.

5.1.1 Basic and Advanced Basic Life Support Patient Care Standards

The *Basic Life Support Patient Care Standards (BLS PCS)* (MOHLTC, 2018b) guides the minimum mandatory level of care to be provided to patients by paramedics in Ontario. The *BLS PCS* (MOHLTC, 2018b) provides guidelines for assessment, treatment, and additional resources for paramedics to consider for further consultation or assistance for different medical, traumatic and other conditions. The standard applies while a paramedic is on duty, but acknowledges circumstances may occur in which following the standard is not always possible or appropriate and “there may be circumstances and situations in which complying with the Standards is not clinically justified, possible or prudent as a result of extenuating circumstances. Paramedics shall use all knowledge, training, skill and clinical judgment to mitigate any extenuating circumstances” (MOHLTC, 2018b, p.2).

The *BLS PCS* (MOHLTC, 2018b) recently underwent substantial revisions from its previous version (MOHLTC, 2007). The revisions began in 2014, in consultation with the “Working Group” created for the BLS PCS revisions, represented by the following bodies: Ontario Association of Paramedic Chiefs (OAPC); Ontario Base Hospital Group (OBHG);

Ontario Base Hospital Group – Medical Advisory Committee (OBHG-MAC); Ornge, Ministry of Health and Long Term Care (MOHLTC); a subject matter expert (author of a previous version of the *BLS PCS*); Sunnybrook Base Hospital; and Toronto Paramedic Services (TPS). This comprehensive group involved input from across the province (e.g. Base Hospitals, lead management of paramedic services, an educator/subject matter expert, and paramedic services representation) as well as the lead paramedic service and Base Hospital from the Greater Toronto Area. Rural or remote Ontario paramedic services were not specifically represented, except with the Base Hospital groups of these regions and the paramedic chiefs of these regions via the OAPC. Substantial overhaul of the document took place, and it was finalized in 2016 (MOHLTC, 2016). Additionally, the document was created in accordance with the *Living Standard Project*:

...to update, maintain, and disseminate paramedic practice documents. This process recognizes that development and maintenance is a cyclical process in which publication of a revised version is both the end of one process and start of another. Documents are reviewed on set maintenance cycles, but requests for change can also be made on an ad hoc basis.

(MOHLTC EHS, Living Standard Project, 2019)

With the new process it is a living document, which will be continuously amended and updated in accordance with input from stakeholder groups (Living Standards Project Change Request Form, EHS MOHLTC, 2015). The intent is for the document to remain current and reflective of current best practices and research.

Importantly for mental health, the updated version of the *BLS PCS* (MOHLTC, 2018b) incorporates the previous version's "Psychiatric Disorders" section into the "General Standard of Care," in accordance with the *Health Care Consent Act*, 1996 (Ontario), and the *Ontario Mental Health Act* (MOHLTC, 2016). The new section is entitled the "Mental Health Standard" (MOHLTC, 2018b). This section is two and a half pages of the 120 page document and begins in the following way: "[i]n situations involving a patient with an emotional disturbance (e.g. erratic behaviour), the paramedic shall:" There are then seven directives that follow to guide paramedic practice (MOHLTC, 2018b).

The first directive advises paramedics to consider underlying organic disorders. This refers to consideration of medical events or trauma which might impact behaviour, such as confusion or agitation in the case of hypoglycemia (low blood sugar), hypoxia (not enough oxygen) or a traumatic head injury. The second directive addresses cases of known or suspected suicide attempts or self-harm and indicates that all attempts must be assumed to have serious intent, and that the patient is to be asked directly if they have thoughts or intent of suicide or self-harm. A third directive addresses patients being transported without consent and the relevant content of the *Mental Health Act* (1990), which will be discussed below. The remaining *four* directives in the Mental Health Standard advise about paramedic safety, and violence, or aggression. In total the directives around safety and aggressive patients comprise approximately 2 pages of the 2.5-page standard. This Mental Health Standard is the only written one in the provincial policies guiding paramedic practice as it directly affects care provision for individuals with potential mental health needs or potentially related behaviours.

Excluded from the standard are guidelines around assessment of patients with mental health needs (except for a brief mention of those with thoughts or attempt of suicide or self-harm), guidelines around management of individuals in emotional or psychological distress, or resources for mental health support and services that paramedics may connect with, except in the case of violent and aggressive patients. This limited guidance in the management of mental health calls presents potential challenges on the front-line and raises questions: about what guides paramedics' care provision for those recipients in crisis or with mental needs without aggression or violence? In addition, how are aggression or violence mitigated?

The *Advanced Life Support Patient Care Standards (ALS PCS)* (2018) is the other standard of care, reflecting current practice and benchmarks for performance of care by paramedics in Ontario. This document contains the protocols and directives for medication administration, and any other advanced life support procedure, for example insertion of an advanced airway (e.g. endotracheal intubation or King LT airway) for which there is either a protocol or directive for paramedic provision of care (MOHLTC, 2018b). There is no specific protocol or directive, or reference specifically to mental health care provided by paramedics in the *ALS PCS* (2018). The only related protocol is the "Combative Patient Medical Directive" for Advanced Care Paramedics (ACPs), which is a directive for the administration of Midazolam, a sedative medication. The indication is for administration for "a combative patient," and the

conditions are that there are “no reversible causes (e.g. hypoglycemia, hypoxia, hypotension)” (MOHLTC, 2018b, p.142).

Aside from the *BLS PCS* (2018) and the *ALS PCS* (2018) there are no other provincial guidelines or directives written for paramedics to guide their practice in providing care for individuals with mental health needs. The *Mental Health Act* (1990), described in section 5.1.2, provides generic guidelines as related to the legal system around issues of self-harm as referenced in the *BLS PCS* (2018). Additionally, in section 5.1.3 I review the *Ambulance Act* (1990) in its regulation of transportation destinations and receiving facilities for patients by paramedic services.

5.1.2 The Ontario Mental Health Act (1990)

The *BLS PCS* (MOHLTC, 2018b) refers paramedics to the Ontario *Mental Health Act* (1990) relevant to paramedics and to the management of certain individuals in the prehospital setting. This document does not directly mention paramedics, however is a relevant policy in paramedic practice with regard to awareness of the circumstances in which individuals in their care may be apprehended by or already in care of police, ordered to have assessment by physician or otherwise impacted by the content of the policy. Specifically, this section lays out the conditions under which patients may be transported without their consent: application for assessment signed by physician (subsection 15(1)), order for examination signed by Justice of the Peace (subsection 16(1)), person taken into custody by police (subsection 17), or patient detained in a psychiatric facility under certificate of involuntary admission (subsection 20(4)) (MOHLTC, 2018a). Ultimately, the decision to transport a patient without their consent in the case of a mental health consideration is not the decision of a paramedic per se, it is that of one of the individuals outlined above. The relevance to calls in the prehospital setting however are that the paramedic is then often involved in the transportation of individuals in community settings to a hospital receiving facility and may be one of the first responders on scene encountering individuals impacted by this policy. The paramedic may be responsible on scene for notifying police if they have determined that a patient requires transport to hospital, even if they do not consent. Despite an individual being apprehended by police under the Ontario *Mental Health Act* (1990) or the order signed by physician or Justice of the Peace, paramedics are often still involved in the on scene and en route to hospital care and management of those individuals.

As per the *Mental Health Act* (1990), the circumstances guiding a physician, Justice of the Peace, or police officer to deem an individual to be in need of psychiatric assessment (even if involuntary) include a number of criteria. Criteria include that of an individual that has or is currently threatening or attempting to cause harm to themselves or others, those behaving violently towards others, causing fear of bodily harm, or an individual showing lack of ability to care for themselves. Additionally, the physician/Justice of the Peace/police officer is “of the opinion that the person is apparently suffering from mental disorder of a nature or quality that likely will result in” harm to self, others (Mental Health Act, 1990). As such, if a paramedic is on scene with an individual, and identifies the aforementioned criteria, it is the responsibility of the paramedic, if the person is in their care, to ensure police are notified and/or that the individual is then transported for mental health assessment by physician.

In the Ontario *Mental Health Act* (1990), it provides fairly clear cut criteria for harm to oneself or others, or inability to care for oneself, indicating that an individual in any of these circumstances may be transported to hospital without consent for psychiatric assessment. These criteria are important for ensuring the safety and wellbeing of individuals with mental health needs as well as those around them. Of consideration however is that the definition of ‘mental health’ referred to in the *Mental Health Act* (1990) originates from the *Health Care Consent Act* (1996), and provides a description for ‘mental disorder’ as “any disease or disability of the mind,” without outside reference, and presents only one way of describing or explaining experiences of “mental disorder” (White & Pike in LeFrançois et al., 2013). The interpretation and understanding of mental health and ‘mental disorder’ in the *Mental Health Act* (1990) has significant implications for individuals as it may result in apprehension for psychiatric evaluation without consent of an individual in distress.

5.1.3 *The Ambulance Act* (1990): Policy and the transportation of patients

Transportation of individuals by paramedic services is guided by the *Ambulance Act* (1990). This act mandates a number of different areas of function of paramedic services including standards for patient care, documentation, safety, equipment requirements and transportation, and specifically directs the destination for transportation of patients by ambulance (Ambulance Act, 1990). The *Ambulance Act* (1990) has up until most recently, determined that patients must be transported to a hospital receiving facility. This has limited transportation of

patients to the emergency department without other options. More recently, as of 2017 the *Ambulance Act* (1990) has been opened up to include the possibility of transportation to facilities other than hospitals, that might be deemed most appropriate for the patient's needs. The decision to transport patients to facilities other than hospitals however is further impacted by policies such as the *Public Hospitals Act* (1990) and the *Ontario Health Insurance Act* (1990), which dictate the procedures and pathways for billing since it is the hospital that is currently paid for transportation by ambulance. Given the influence of these acts, the likelihood of regions and institutions allowing for alternate destination options beyond the hospital emergency department (ED) will not only be influenced by changes made to the *Ambulance Act* (1990).

The limits to transport destinations have implications for care provision for individuals in psychological distress because it constrains the ways in which paramedics are able to offer care, and the options for those seeking care. For instance, the ED as a destination for individuals with mental health needs has been critiqued as problematic, as a place not designed specifically for mental health care, and in many cases, further exacerbating an individual's level of distress (Clarke et al., 2007; Wise-Harris et al., 2016), a theme that will be further explored in Chapter 7 The Conditions of Work and Care and in Chapter 9 Mental Health Projects and Programming in Paramedic Services: Promising Practices and Future Directions.

5.2 Policies impacting the type and volume of mental health and psychosocial care needs

Understanding possible causes for the increase in mental health and psychosocial call volume requires policy context beyond the paramedic services level. In this section the policy contexts of deinstitutionalization and resultant shifts in community mental health services are explored below to inform further understanding of the possible factors impacting mental health needs in the community. Finally, the role of neoliberalism in mental health and social policy will be discussed.

5.2.1 Deinstitutionalization and shifts to community care

Deinstitutionalization refers to the movement of treatment and care into the community for those that were previously in long-stay mental health facilities (Richman & Harris, 1983). Deinstitutionalization has often been thought of as a distinct event that occurred in Canada in the 1960s and 1970s, however as Sealy & Whitehead (2004) point out, it has in fact been occurring

continuously for more than forty years. In Canada between 1960 and 1972 there were 43% fewer patients in public ‘mental hospitals’ and between 1970 and 1978-79 there was a 50% decrease in beds in ‘mental institutions’ including ‘mental hospitals.’ These decreases were present in essentially all provinces (Barnes & Toews, 1983); however, the process and timing of deinstitutionalization, along with the extent to which community mental health services have been put in place to account for this shift has varied drastically by region within Canada (Sealy & Whitehead, 2004).

In 1891, four main ‘asylums’ existed in Ontario: Toronto, Kingston, London and Hamilton. Spending on asylums nationwide between 1845-1902 was more than on prisons and others hospitals. In 1930, there was interest in greater community-based care through mobile mental health units in the community; however with underfunding and high demand, they were discontinued and in 1946, the Deputy Minister of Health attempted a community care plan creating ambulatory mental health care in the community through public health units (Mulvale, Abelson & Goering, 2007). Simmons (1990) asserts that there was never a clear cut policy in Ontario aimed at “reducing the population of provincial psychiatric hospitals and establishing community services to receive discharged patients,” however the policy of deliberately reducing long-stay populations in large mental health hospitals began in 1965 (p. 160). He states that the process of deinstitutionalization came about “slowly and in an ad hoc fashion” and has lacked a coherent aftercare program (p. 160). In the 1960s and early 1970s, there was a shift of many chronic patients from psychiatric hospitals to other long-term care facilities, and many discharged to the community with limited or no community supports. This often resulted in repeated relapse and readmission often to general hospital psychiatric units, or in some cases homelessness or incarceration (Mulvale et al., 2007). By the 1980s, hundreds of community-based, non-profit agencies had formed under the Canadian Mental Health Association (CMHA) to offer a range of services not otherwise provided (eg. residential, vocational rehabilitation, income support and case management) (Mulvale et al., 2007).

Despite the substantial decrease in institutional care, only 3% of the provincial mental health budget in Canada was allocated to community support by 1990 (Mulvale et al., 2007). In 1993, a 10-year plan for delivery of mental health services was published by the MOHLTC. At that time, there were 14 psychiatric hospitals in the province along with psychiatric units in general hospitals receiving about 60% of the mental health care funding. The remaining 40%

went largely to physicians and community mental health service providers (Annual Report of the Office of the Auditor General of Ontario, 2016). As a part of this plan, the Health Services Restructuring Commission was established in order to improve access, quality and cost-effectiveness of health services in Ontario. The Commission determined that the closure of psychiatric hospitals and merging with general hospitals would reallocate funding to community-based mental health services (ibid). In the early 2000s, 10 of the 14 psychiatric hospitals were closed or merged with general hospitals leaving four specialty hospitals that currently exist in Ontario: Centre for Addiction and Mental Health (CAMH), Toronto; Ontario Shores for Mental Health Sciences, Whitby; The Royal Ottawa Health Groups, Ottawa and Brockville; Waypoint Centre for Mental Health Care, Penetanguishene. For the remaining four specialty psychiatric hospitals, there are no provincial mental health standards for admission, treatment, and discharge with different treatment from hospital to hospital and no plans to establish a standard (ibid), although there are differences in specialization at each facility.

In 1961 there were 15, 602 patients in psychiatric hospital and residential units, (Simmons, 1990) and as of 2016, there were approximately 2760 long-term psychiatric beds across 35 facilities (primarily in hospitals) throughout Ontario. Loss of beds has been as recent as between 2011/2 and 2015/6 where there was a decrease in 134 long-term psychiatric beds (Figure 5.1). The Annual Report of the Office of the Auditor General of Ontario (2016) critiqued that the MOHLTC has not ensured sufficient beds in other health care facilities such as supportive housing or LTC for those patients discharged from specialty psychiatric hospitals (Annual Report of the Office of the Auditor General, 2016). This is problematic not only for those individuals ready to move back into the community, but also, in delaying the number of patients able to be treated.

Figure 5.1 Changes to Long-Term Psychiatric beds in southern Ontario between 2011/12 and 2015/16, by region

| Region | Psychiatric beds gained or lost between 2011/2012 and 2015/2016 |
|---------------------|--|
| Thunder Bay | -36 |
| Timmins/North Bay | -2 |
| Ottawa | +6 |
| Kingston | -85 |
| Peterborough/Oshawa | +20 |
| Penetanguishene | +1 |
| Toronto | -4 |
| Guelph | +16 |
| Hamilton | +36 |
| London | -110 |
| Windsor | +24 |

(Annual Report of the Office of the Auditor General, 2016, p.622)

These beds apply for children, adults, seniors and forensic patients. In the community, with services often rendered by family physicians covered by OHIP, rather than paying out of pocket for services which are often private such as psychologists or in some cases social workers, demand for and use of physician services increased significantly. In 2001/2, the most frequently billed OHIP fee code by physicians was psychotherapy (Mulvale et al., 2007). General hospital ED visits in Ontario are increasing, with a 21% increase in general ED use for individuals with mental health and substance use needs in the last 5 years (Annual Report of the Office of the Auditor General, 2016). The Report notes that the MOHLTC has not carried out any analysis to determine possible causes for the increase. It also states that the increase could be partially attributed to a lack of mental health care emergency services.

Figure 5.2 Growth in Unscheduled Repeat ED Visits within 30days for Mental Health and Substance Use in Ontario 2011/12 - 2015/16

| | Growth between 2011/2012 and 2015/2016 |
|--|--|
| Unscheduled Repeat ED Visit within 30 days for Substance Use | 18% |
| Unscheduled Repeat ED Visit within 30 days for Mental Health | 9% |
| Ontario Population Growth | 4% |

(Annual Report of the Office of the Auditor General, 2016, p.636)

Figure 5.2 presents the growth in unscheduled, repeat ED visits within 30 days for individuals with mental health or substance use conditions. While not specifying the number arrived by ambulance versus those arriving at ED by other means, this indicates a significant increase in repeat ED visits between 2011/2 and 2015/6.

The origins of deinstitutionalization of patients from psychiatric facilities has been attributed to the advent of psychopharmaceuticals in the 1950s in improving symptom control for many individuals struggling with mental health. Additionally, however, financial considerations have played a large role in the ability to shift costs from institutions into the community (Sealy & Whitehead, 2004; Simmons, 1990; Whitaker, 2010). Criticism of deinstitutionalization has primarily been around the ways in which it has been carried out, rather than deinstitutionalization itself (Barnes & Toews, 1983). Milligan (2005) notes that “deinstitutionalisation is not viewed as simply a change in the locus of care, but that we are cognisant of the ways in which the individuals and the environment (e.g., the social setting in which the individual resides and interacts) can create inequities” (p.219). This has led to a new issue of ‘revolving door’ individuals who have chronic mental health needs but challenges in accessing care (Milligan, 2005).

5.2.2 Neoliberalism in mental health and social policy

Shifting care for individuals with mental health needs from hospitals and institutions into the community, to families, and to individuals reflects pervasive neoliberal ideologies (Teghtsoonian, 2009). Neoliberal ideologies include an emphasis on “free” markets with limited state regulation and intervention, lesser taxes and social provisioning and responsibility of the

individual rather than market for poverty and poor living conditions (Bezanson & Luxton, 2006). In its origins, neoliberal thought developed in opposition to socialism and in defence of capitalism (Braedley & Luxton, 2010). Its history has been discussed by David Harvey (2005) and it has been described as “the rationalization of a late stage of capitalism” resulting from a need for flexible accumulation (Braedley & Luxton, 2010, p.29). While neo-liberal policies decentralize responsibility and social provisioning away from the state, such policies often centralize power to certain decision-makers making the state and provinces less democratic by shifting decision making outside of elected assemblies and “devolving and downloading responsibilities for key aspects of social reproduction to lower levels of government (e.g., municipalities) and to individuals (decentralizing blame) (Bezanson & Luxton, 2006, p.4). Neoliberal policies impact social provisioning and necessities associated with social reproduction relevant to maintaining good mental health. Additionally, neoliberal cost cutting creates limitations to the ways in which care is provided and is felt on the ground by both care providers and care recipients (Dyck et al., 2005).

While acknowledging the problematic nature of many mental health hospitals and institutions that existed prior to deinstitutionalization, it is also necessary to examine the problem of placing the burden of costs and responsibilities for care off of the public domain and onto the private. Placing responsibility on individuals, families, workplaces and communities for the support, maintenance and care of mental health and wellbeing is consistent with neoliberal ideology that is prevalent in mental health discourse, policy and many services (Teghtsoonian, 2009). Movement of mental health services into private domains reduces or eliminates state responsibility for mental health and wellbeing (Carney, 2008). In other words, while undoubtedly problematic in many respects, institutional care meant that care for mental health was essentially provided in one place, and was publicly funded. Shifts to community care drive needs for outreach services, which decentralize and diffuse responsibility for who receives supports and services (Carney, 2008). Care is no longer centrally received in one institution or by one service, but by potentially multiple services. Responsibilities for funding and service provision are also decentralized among different services with some care based in hospitals, with physician services, and with other community mental health services, which may be publicly funded. Psychologists and social work services are often private, requiring out of pocket payment (Annual Report of the Office of the Auditor General, 2016). This diffusion of

responsibility and payment has resulted in poor integration of community mental health services and lack of continuity of care in Ontario (Mulvale et al., 2007).

Individualistic, neoliberal ideologies impact the understanding of mental health and the factors relevant for its maintenance and wellbeing. Morrow (2017) states; “by prioritizing psychiatric and acute mental health care, the mental health system, under neoliberal regimes, has assured that biomedical understandings of mental distress have prevailed over paradigms that emphasize the role of equity and social supports in mental health” (p.44). Furthermore, this ideology places emphasis on response to acute care needs rather than preventative measures, optimizing the conditions which lead to and support good mental health. Neoliberal policies place the responsibility for mental health at the individual level, with a focus on disorder and illness. The means for managing mental health needs at the individual level include pharmacological interventions to change or ‘fix’ disordered thinking and behaviours (Carney, 2008; Esposito & Perez, 2014).

With its agenda of privatization, consumerism, fiscal restraint, privileging of the “free” marketplace, and wholesale retrenchment of social services, neoliberalism has paved the way for a new “shallow” relationship between the individual and the state...In so doing, it has fashioned a new kind of self-monitoring psychiatric consumer whose “mental illness” is purely an individual concern to be managed through self-caretaking, the administration of expert technologies and, where necessary, aggressive health interventions that proceed without any gesture towards the structural roots of human distress.

(LeFrançois et al., 2013, p.16)

Morrow (2013) describes the age of neoliberalism as having brought in the “healthification of social problems” (LeFrançois et al., 2013). Policy focus at the individual level draws attention away from the social, political and economic structures that impact individuals’ mental health, and potentially create very understandable distress for individuals and communities. Neoliberal policy responsabilizes the private sphere of care to manage mental health, away from the structures and institutions such as publicly funded supports and services (Braedley & Luxton, 2010) and other determinants of good mental health such as housing, food security, income, employment, working conditions and so on (Mills, 2015). Decentralized services and limited

publicly funded options constrain individuals' agency regarding service use and access and impact an individual's likelihood of arriving at a point of crisis.

Neoliberalism perpetuates individualistic ideals such that the 'mentally ill' are 'consumers' or 'users' of mental health care and psychiatry is simply a benign provider of choices for treatment and care (LeFrançois et al., 2013). Poole and Ward (2013) extend that the growing list of *DSM* disorders can be traced to neoliberalism for example in its discourse on responsible and productive citizenship, placing boundaries on normality in timeframes for recovery from grief, impacting what is seen as disorder and potentially how it is treated or supported. They assert that the *DSM* indicates a six-month limitation on the grieving period before considering the individual may be 'disordered,' while perhaps grieving for longer might be right for that individual and there is not necessarily something 'wrong' with them. It might however prevent them from returning to paid work in the timely, desired manner required of a productive citizen. Along with this framing of grief, understandings of recovery from distress or mental ill-health have been guided by neoliberal agendas. "What is often overlooked within discussions of recovery is an explicit recognition of the role of the social, political, cultural and economic context in which people become mentally distressed and recover" (Morrow, 2013, p.325). Recovery is then framed as an individual experience and journey, aligning with the neoliberal agenda of cutbacks to the welfare state and social supports. For both recovery and maintenance of good mental health, this framing of recovery detracts attention from the context in which they occur – the contexts in which poverty, homelessness, racism, homophobia, sexism and other determinants have real consequences and implications for one's mental health and mental health needs (Morrow, 2013).

The pervasive presence of neoliberal ideologies in not only mental health policy, such as the inadequate shifting of funding from institutions into community mental health care and other determinants of mental health but also to other health and social policies, has implications for mental health and wellbeing. These implications include social isolation and lack of social support, which are critical components for supporting good mental health and wellbeing (Allen, Balfour, Bell & Marmot, 2014; Wiktorowicz, 2005). A lack of social supports and neoliberal influences on social, political and economic systems impact mental health outcomes (Mills, 2015; Teghtsoonian, 2009), and may have implications for the psychosocial calls encountered by paramedics. As care is shifted into communities, such as more care provided in home, such

shifts in *where* care takes place impacts *who* is responsible for it (Milligan & Power, 2009). As family, friends and neighbours play an increasing role in care provision where few other supports exist without additional financial cost (Milligan & Wiles, 2010), in what ways does this result in paramedics being called to homes and non-clinical settings, especially when individuals exhaust other supports? Those with chronic illnesses are receiving more care through episodic, rather than continuous, care modalities - through walk-in clinics, EDs and 9-1-1 (Braedley, 2010). Feminist political economy analyses highlight that with an overarching policy focus for care provision on cost-shifting and -cutting, social care responsibilities are decreased for the public system and increased in the private sphere (Daly, 2013). Specifically, the social provisioning such as everyday social care and mental health supports required for good mental health and social reproduction is significantly decreased (Haley, 2017).

Through the shift of costs associated with mental health care from the public sector to the private, there are real implications for accessibility of mental health supports for individuals. Many mental health supports and counselling services are available only through workplace benefits or out-of-pocket expenses (Brien, Grenier, Kapral, Kurdyak, & Vigod, 2015), which limits or eliminates this option for others struggling with mental health. Both for privately-paid services as well as publicly-funded community mental health supports, long wait times are often a reality for those seeking support. Community supports may be at capacity, limiting individuals' ability to access these supports when needed (Wiktorowicz, 2005).

5.3 Paramedic policy perspectives

This section presents findings about how paramedics identified a lack of standards for mental health call management. I then outline paramedics' descriptions of increased mental health call volume in relation to deinstitutionalization as well as gaps in community mental health and social services. Finally, I present paramedics views on the challenges with providing mental health care in the prehospital setting and some of the ways in which they are constrained in providing this care.

5.3.1 Lack of guidelines

Paramedics in the study referred to a lack of guidelines or standards in managing mental health calls. One paramedic with nearly 17 years' experience described her perspective:

“We don’t really have any kind of tools or, I mean a lot of us can use our experience as we go...but as far as mental health, there’s really nothing. I mean, we go to a chest pain call, we’ve got our protocols, you know and we’ve gotta put the monitor on, and we’ve gotta, you know check their vitals and ...you know...ASA (laughs), you know, we know what to do. But for mental health there’s nothing! There’s no set kind of...and one, because no patient fits the book and two, because there’s really, there’s nothing. We have no set rules as to what to follow and how to handle a patient in any given state of mind...it’s, it’s basically experience, and you know, flying by the seat of our pants basically. You know, shit luck really (laughs)”

(Front-line paramedic: Interview 016, 2018)

This paramedic refers to patients with chest pain for whom there is a clear protocol for assessment and management – for example putting the patient on a cardiac monitor, considering the administration of Aspirin (or ASA), and other clear cut assessment tools. In contrast, with mental health calls, there are neither clear protocols, nor defined assessments or guidelines for paramedics to follow.

One paramedic educator and front-line paramedic highlights the lack of standard assessment tool or guideline for managing mental health calls:

I still certainly think we’re lacking in any kind of tool to assess and manage psychological crisis in patients. And I still don’t think we...have a good analytical checklist.”

(Paramedic educator and front-line paramedic: Interview 035, 2018)

These interviewees were among many who referred to a lack of guideline or policy in managing mental health calls. Paramedics discussed most of their practice for mental health care arising from on-the-road experience and trial and error. They referred to a lack of guidelines or standards in assessments or care provision as challenging when attempting to provide mental health or psychosocial care, as well as not having a clear understanding of whether or not they have done a good job providing care.

5.3.2 Increasing mental health calls and deinstitutionalization

Despite the lack of guidance for managing these calls, paramedics did identify what they felt was an increase in mental health calls for paramedics. Many medics associated this with the closure of local mental health institutions. In reflecting on the increase in mental health call volume to paramedic services, paramedics from multiple paramedic services referred to the closing of mental health facilities, and referred directly to “deinstitutionalization.” Paramedics spoke of individuals requiring care, being shifted from mental health facilities into the community, with a lack of community services or at the very least a lack of ability to access required community mental health services. Paramedics in this study referenced relatively recent closures and downsizing of larger mental health facilities as having impacts on their community and volume of mental health related patients, and identified changes to these calls and volume seen throughout the course of their career. One front-line paramedic with seventeen years’ experience describes her understanding of deinstitutionalization and the impact it has had on mental health needs:

Mental health is...is a lot more lately than I’ve ever found. I think because we’ve had some facilities close here so it tends to fall on the emergency services a lot, between police and us.

(Front-line paramedic: Interview 006, 2017)

One paramedic described what they felt to be the result of closing mental health hospitals in the city in which they work:

There’s also the problem...I feel like I’ve talked about this a lot... one of the bigger problems is that...there was a really large facility for...people with uh...diagnosed...mental illness in {name of town}...It was probably the size of like...I dunno, six football fields...it’s gigantic. You can still see it, the facility’s still there. But they closed it down, kicked everybody out. So then they all came to {name of city} and some of them went to {name of another city}. And then {name of city} had the facility...and it could maybe accommodate a third of what came from {name of town}, so a lot of those people came out and spilled out into the outlying population. And then recently within the last three years...that facility closed down and it went to a facility that can only accommodate, probably...a third of what that facility would accommodate. So now these people are kind of...orphaned in the community, with their...with their illnesses, and they’re not really able to manage themselves, and there’s

a lot of good community programs out there but they don't do an adequate job. Because there's a lot of these people that do need to be consistently monitored and managed and treated and...they're not really able to be left to their own devices.

(Front-line paramedic: Interview 002, 2017)

Another paramedic also referred to the closure of mental health facilities and the resulting challenges to navigating support without centralized mental health facilities or institutions.

And I feel like when all these centres closed down, that's when our mental health calls just exploded. Because these people went from having sort of the resources that they needed to not knowing how to navigate outpatient type resources.

(Front-line paramedic: Interview 029, 2018)

5.3.3 Community mental health services and calls to paramedics

Fragmented supports in community mental health services were described by one paramedic as he spoke of a recent encounter with an individual in distress who had been unable to consistently access required resources:

...the biggest problem is, is all these agencies are fractured and we all have just a little piece and we all have different protocols and, and so there doesn't seem to be any good flow of communication between them all to, to how to deal with it... I think there's all these agencies out there and they're all doing these little things, but nobody maybe knows what the other guy is doing and there's no, there's no collaborating and it's you know...bureaucracy gets in the way.

(Front-line paramedic: Interview 008, 2018)

Another paramedic spoke with frustration at the gaps and lack of available or accessible supports for individuals in distress and in need of support:

We need more counsellors, we need more shelters, we need more emergency beds for MH {mental health} patients. We need to get them off the street. How do you...if you had...if you broke your leg and we said, well, you know what, we just don't have any crutches left...so if you wouldn't mind...we're going to have them in about two weeks, so, just kind of hobble around and try not to step on that broken

leg... That's what they're telling MH patients. We'll be with you, in the meantime, try and cope as best you can.

(Front-line paramedic: Interview 003, 2017)

Both for those with more severe or chronic mental health concerns, timely access to appropriate mental health supports and services presented as an issue, as well as for those experiencing more temporary mental health concerns. Leaving even the less severe needs unaddressed increases the likelihood that they may develop into more severe or more chronic problems without the appropriate supports.

But we have so many people with...generalized anxiety disorders and depression and whatever, that they don't see counsellors because they can't afford it and there are no resources for things like that, because it's all paid out-of-pocket for the most part, unless you have benefits and most of these people don't. Or they've been through a treatment program, but there's not enough money in your therapies and things that help people get better, not just throwing medication at them.

(Front-line paramedic: Interview 030, 2018)

With regard to accessing crisis and acute mental health care services, paramedics described how they are often activated in the community because few other social and mental health services are available 24 hours a day, 7 days a week, holidays included. They reiterated that distress and crisis do not occur only Monday-Friday during business hours, and outside of this, there are often few places for people to turn.

Paramedics gave examples even of 24/7 crisis lines that ultimately advise people that they will be contacted after the weekend to then be connected with support.

...we really need to at least have access to everything 24 hours a day, at the very least, there should be a number they can call or a person they can contact 24 hours a day and say, here's the resources, here's what we have. Right now they're just being told, so if you call the {mental health agency} line, and again, this is from personal experience, somebody will be with you on Monday.... So I called the emergency number and the emergency number says, yes, unless your person is in the hospital, then I'm just basically here to take your name and number. Well that's not a hotline, that's just an answering service. So that was very frustrating to deal with, so I said who else can I call, so they said, well there's, you'll have to talk to a counsellor. Well, what's the point

then of having this 24-hour number? People need to be directed. People who are lost need direction, and these people are lost. Family members and patients are lost.

(Front-line paramedic: Interview 003, 2017)

One mental health educator in a college paramedic program in Ontario described the gap of appropriate and accessible mental health services as something that falls to paramedic services, yet a problem that is far beyond the scope of paramedicine to solve:

Yeah, I mean I don't have any solutions that are focused strictly on paramedicine. This is an issue that's societal. And we have to be better funded for community based mental health services because people are dying and they're suffering and they're untreated. And a wait list for one year for case management services is despicable. We would not expect that for any sort of other sort of illness in our community...Right? And unfortunately, while it's not paramedics that own this issue, you know, the solutions don't lie in paramedicine. They're the ones that are carrying it, you know? They're the ones that are going to get involved every day on some mental health crisis that could have been averted had that person had adequate appropriate time to care. That needs to happen. So, on a macro level, that's sort of this broad systems change.

(Educator in an Ontario college paramedic program: Interview 039, 2018)

In identifying gaps in services, paramedics discussed patients lacking other mental health care and social care options, resulting in calls to paramedic services. One manager in a paramedic service described calls received by paramedic services as occurring when people are at a loss for other supports or services:

There seem to be a lot of those psychosocial call types where it's people who are just looking for supports, looking for an outlet, they don't know who to turn to and their default is always 9-1-1.

(Manager in an Ontario paramedic service: Interview 032, 2018)

5.3.4 Paramedics and mental health care: Not the ideal option?

Paramedics described the default to calling 9-1-1 as a less than ideal option for individuals with mental health needs, suggesting there ought to be more appropriate mental health or social supports.

Well ... in an ideal world 9-1-1 wouldn't get involved too, too often with people with mental illness, they would have other people to call that are more ... that can get them the help that they need. 9-1-1 is obviously always going to be required for some situation, I mean, excited delirium, actively suicidal, that's obviously our job to respond and help these people. But for everything that's more of a minor issue, if they had the resources that they need we hopefully wouldn't get ... be involved as much because ... but often people default to calling 9-1-1.

(Manager in an Ontario paramedic services, 2018: Interview 035, 2018)

Paramedics also highlighted that paramedics are often not the ideal option for providing mental health or psychosocial care given paramedics' limited resources in providing this type of care.

...but we're the only ones that they know to call. But we're the ones that can least do this, do the least amount of help, 'cause we don't have the resources.

(Front-line paramedic: Interview 016, 2018)

One paramedic describes mental health care provision as something somewhat unexpected that paramedics have taken on, not necessarily appropriately, but because they are one of few options for providing care:

...so it's kind of like a bit of a mismatch between a lot of our thought ... maybe we should be dealing with them, we don't have the expertise... directly related to helping them, but we just bring them to a place where they then get ... shipped off to somewhere else to talk to someone right? Um...(sigh) so I mean long story short, I feel like in society these days there is a role for us to help them...and that's just, that's just the way that the progression has went. Like, I feel like it's unfortunate and I feel like there would be other organizations that would be better suited, but you know, their organizations aren't connected to 9-1-1 and they would send that resource and with liability insurance it just doesn't work out that way that you can do that...So...right now, we're kind of the only option to call...I don't think that it's the right option, but...I think that that's the way it kind of has to be, until something else gets figured out

(Front-line paramedic: Interview 022, 2018)

When speaking about why paramedics are not necessarily the ideal service for managing mental health care, one recurrent theme was having the ED as the only destination for these patients. A senior member of management described that currently, the *Ambulance Act* (1990) dictates patient transport destinations and options to veer away from this as a destination for patients with mental health needs were limited.

So, they've opened up the Ambulance Act to say we should be looking for alternate destinations, treatment and these types of things. But the problem is, the Ambulance Act in all its glory can be fine opened up, but what defines where paramedics and ambulances take patients is actually in the Public Hospitals Act and in the Ontario Health Insurance Act, that define where we need to take patients as they have to have hospital designation. And this is one of the issues they ran into in {anonymous location} where paramedics can't transport directly to this crisis centre, because the crisis centre isn't affiliated with the hospital and they don't have section 4-2 designation through, I think its Public Hospitals Act. So, as we're looking to the future and we're building some of these facilities, these alternate destinations, it's important to remember that piece.

(Paramedic Management in an Ontario paramedic service: Interview 034, 2018)

Paramedics spoke of how the ED was often not the ideal place for individuals with mental health distress.

Whether it's a crash bed, whether it's... a 24-hour... treatment centre if you've got drug and alcohol problems, even if it's just to stay for twelve hours, just to start the process. Somewhere other than the emergency department

(Front-line paramedic: Interview 003, 2017)

Ultimately, despite the ways in which paramedic services and the care destination of the ED to which paramedics must transport patients, paramedics identified that often it was gaps in other parts of the system that resulted in them attending mental health or psychosocial calls

5.4 Discussion

Neoliberal ideology guides both mental health and social policy in the Ontario context. Neoliberal ideology perpetuates the biomedical understanding of mental health as something to

be “fixed” and managed by individuals and with individuals as ‘consumers’ simply making ‘choices’ in their mental health care. It frames recovery as an individual journey largely without social, political and economic context, and within time constraints of returning to work as a productive citizen. Furthermore, neoliberal ideology has driven the retrenchment of social supports and the welfare state, immensely impacting a range of policies such as housing, income, employment, education and other determinants of mental health along with available and appropriate community mental health supports and services. This ideology significantly impacts the mental health and wellbeing of communities as well as the provision of care that is received. Furthermore, the understanding of mental health and what factors support or are detrimental to mental health have substantial implications for the ways in which supports and services are provided. The following section explores whether neoliberal ideology and policies may impact not only the delivery of paramedic services to individuals in distress, but also impacts the calls seen by paramedic services.

The following sections discuss the tensions arising from deinstitutionalization, shifts in community mental health services and other neoliberal policy implications for individuals in the community. The role of deinstitutionalization and gaps in community mental health services will be discussed, followed by discussion of whether or not paramedics are the right service to be providing mental health care.

5.4.1 Deinstitutionalization and calls to paramedics

Paramedics and paramedic services participating in this study identified that there are more mental health related calls than in the past. Paramedics also discussed the closing of local mental health hospitals and institutions and the changes to care needs and call volume they feel they have seen as a result. In acknowledging that deinstitutionalization has had implications for care needs in the community, it is necessary to acknowledge the tension between having a centralized source of care, but also the historic, significantly problematic nature of many mental health institutions. The practices of mental health care within institutions, were deemed inhumane by many and as such, a movement away from institutionalization offered potential for improved living conditions for many struggling with mental health. Because of an immense lack of coordinated mental health care within the community the circumstances for many failed to improve (Hartford, Schrecker, Wiktorowicz, Hoch, & Sharp, 2003; Nelson, Lord, & Ochocka,

2001; Simmons, 1990). Funding from closures of large psychiatric institutions has generally not been redirected to community-based supports (Barnes & Toews, 1983; Morrow, 2017; Mulvale et al., 2007), resulting in a lack of resources in the mental health care system (Morrow, 2017). Public funding in support of mental health care also then relies largely on a need for *DSM* diagnoses, with little going to preventative supports (Morrow, 2017).

The *Mad Studies* movement and literature with an antipsychiatry lens present significant critique of both the experience of institutionalization and deinstitutionalization through the realities of daily lived experiences for individuals with mental health needs, highlighting the power imbalance at play and often the complete lack of autonomy and rights afforded to individuals with mental health needs:

To be sure, common themes galvanized the antipsychiatry movement in the championing of human rights for psychiatricized citizens, and in its opposition to the burgeoning therapeutic state and the medicalization of everyday life; from arbitrary, exclusionary, racist, homophobic, gender-biased diagnostic codes and interventions; to involuntary mental confinement and enforced “treatment”; to electroshock, Big Pharma, and the profusion of chemical straightjackets branded as therapy; and increasingly to systemic deinstitutionalization and the wholesale urban ghettoizing of ex-patients under the transparent deceit of “downsizing” and “reintegration.”

(LeFrançois, Menzies & Reaume, 2013, p. 4-5).

LeFrançois et al., (2013) note that deinstitutionalization alone was often presented as at fault for creating social inequities among psychiatric survivors, not acknowledging the extensive systemic prejudices and underfunding that followed with deinstitutionalization. Again this problematizes not deinstitutionalization alone, but the ways in which it has been carried out.

Despite the immense challenges facing individuals with mental health needs, such as lack of housing or appropriate housing, lack of income and employment opportunity, continued social exclusion, and lack of appropriate mental health supports (LeFrançois et al., 2013; Warne, 2013), there were positive outcomes in this era of deinstitutionalization. The Ontario Mental Patients Association (OMPA) formed in 1977 as the only group run by ex-psychiatric patients with a vision for autonomy. In years following, other organizations formed, such as the Ontario Psychiatric Survivors’ Alliance (OPSA), Phoenix Rising, and the No Force Coalition (NFC)

representing lived experiences and working to address the histories and ongoing needs and immense challenges facing psychiatric survivors (Costa, 2013).

Davidson et al. (1996), explored the perspectives of service users and their experience and preference for mental health care in the community. Positive aspects of care in the community include: freedom; autonomy; privacy; safety; mobility and proximity to their own community. The positive aspects included not having the stigma, rejection, loss of freedom and limited access to friends and family that were identified with hospitalization. Negative aspects of care in the community include: loneliness; lives devoid of meaningful activity or contact; and living in considerably impoverished conditions with regard to housing, food and resources for daily living. While overall, service users state a preference for community living over hospitalization, there are some clear disadvantages for community living (ibid). As previously identified, these disadvantages lie significantly in the availability and types of supports and services for mental health specific and other social supports, that exist for individuals in the community (Hartford et al., 2003; Nelson, et al., 2001; Simmons, 1990).

5.4.2 Community mental health services: Gaps in care

There is a substantial critique of the community supports since deinstitutionalization began more than forty years ago (Sealy & Whitehead, 2004). A lack of coordination of service providers negatively impacts continuity of care for individuals with mental health concerns, with implications for health and mental health outcomes such as deteriorating health status, decreased social functioning, further hospitalization as well as homelessness (Wiktorowicz et al., 2010). Continuity of care for those with mental health needs is impacted by a lack of coordination and integration of services, occurring as many services remain siloed, and dealing with competing interests. As well, there are complexities for coordinating different supports including health, housing, social assistance, addiction services as a part of community mental health services, with limitations in communication and integration among services (Wiktorowicz, 2005). While changes to the structure of the mental health care system were presumably intended to be of benefit to those requiring services, there has been a deterioration in care for individuals accessing fragmented and poorly integrated services and supports (Durbin, Goering, Streiner & Pink, 2006). As the paramedic in section 5.3.3 stated, while there may be many useful services that exist and provide good support, there is often a lack of coordination and communication among

them, leaving individuals lost and not knowing how to connect with them, potentially resulting in crisis and use of paramedic services instead.

Among challenges for accessibility of services in a poorly integrated system, there are challenges with sharing of information between mental health services and service providers. In a system where there are a range of different community, hospital based and even police services involvements for one individual with mental health needs, a system for appropriate information sharing is required (Annual Report of the Office of the Auditor General of Ontario, 2016).

Paramedics identified challenges in continuity of care when paramedic services are involved.

The *Personal Health Information Protection Act* (PHIPA) (2004), places strict limitations on the sharing of individuals' personal health and mental health information. Protection of personal health information exists for the protection of individuals' privacy, however presents implications for continuity in care and challenges for collaborative and cohesive care plans (Azarm-Daigle, Kuziemy, Peyton, 2015; Wiktorowicz, 2005). Communication of information and continuity in care are evidently challenges in a fractured mental health care system. Additionally, however, challenges exist when information being shared may present the patients, their mental health needs and potential diagnoses out of context and in ways that individual do not agree.

Critiques of existent mental health services also speak to the dominant ways in which 'mental health' itself is understood as disease, illness and a problem to be corrected. Community mental health services have been critiqued as means of ensuring service users remain on their medications, regardless of the need, benefit or in fact harm that medications may be doing for many (Shimrat 2013). The understanding of mental health that guides many of these services is found to be devoid of context, ignoring the impact of real-life experiences and trauma that so many in distress have experienced (ibid). Many individuals are obliged to receive community mental health services in ways that may not be beneficial to them and that they in fact may not desire, and with disproportionate representation of specific populations and groups such as children and youth, the elderly, women, racialized people and those who are Indigenous. This critique of community mental health services does not negate the need for community, wellbeing and mental health supports, but in the current form, many services lack a comprehensive understanding of what contributes to mental health and wellbeing and as such, what appropriate support is (Shimrat, 2013).

The quality, accessibility and availability of community mental health supports have important implications for individuals reaching a point of crisis and requiring acute care, potentially resulting in hospitalization. “Although there is a consensus that acute in-patient services are necessary, the number of beds required is highly contingent upon what other services exist locally and upon local social and cultural characteristics” (Thornicroft & Tansella, 2004, p.286). The outcomes of poorly integrated and coordinated mental health services in the community results in increased pressure on EDs, hospitals, police and correctional services (Wiktorowicz, 2005). How this pressure impacts paramedic services is an important question (Roggenkamp, Andrew, Nehme, Cox & Smith, 2018). Since the 1960s, there has been increased contact between individuals with mental health concerns and the police and criminal justice system, frequently resulting in arrest or apprehension, even for minor offenses (Heslop, Stitt & Hoch, 2004). The arrest or apprehension of these individuals has been identified as criminalization of many with mental health needs, in a system where there is significant concern for a lack of community supports (Heslop, Stitt, & Hoch, 2004).

As discussed in Chapter 2, understandings of what are ‘mental health’ and ‘mental disorder’ arise from a number of different domains with implications for mental health supports and services. Importantly, it is necessary to recognize how it is understood in the legislation. Noted in the previous section, is the criminalization of many individuals with mental health needs in the community, presenting the question of how ‘mental health’ is understood in the policy context, and what implications this then has for individuals now residing primarily in the community. Individuals struggling with mental health may be significantly impacted by ambiguous understandings of mental health, or at the very least, a lack of consensus, as applied in legal and policy matters. The ambiguity in this understanding of mental health, potentially varying in policy, or as with the Ontario *Mental Health Act* (1990), by role as police officer, justice of the peace or physician - - has implications for individuals’ rights and freedoms, as well as for understandings of what it means to provide care and “help” to individuals with mental health needs.

...in many Western countries, including Canada, mental health inequities continue to be actively promoted by the state, its institutions, and the “helping” professions – purportedly in the best interest of the “mentally ill” – through myriad laws, social

policies, and practices that severely restrict the rights, freedoms, and capabilities of people with (presumed) mental illness diagnoses.

(Malcoe & Morrow, 2017, p.3)

Increased interaction with first response services such as police and the neoliberal policy focus on acute rather than preventative care raises further questions about the role of emergency, acute care providers such as paramedics, as will be explored in the following section.

5.4.3 Mental health and psychosocial emergencies: Are paramedic services the right service?

This chapter has explored the policy contexts impacting not only the care paramedics provide, but also the contexts driving care needs from paramedic services in the community. It is necessary to explore how these shifts in care needs and care responses have occurred, and ultimately, are paramedics the right service to provide mental health and psychosocial care? In this section I discuss this question by analysing neoliberal ideologies influencing shifts in policy and in who is providing care. I discuss the role of paramedics and emergency services filling gaps in other mental health and social policy domains, as well as the limitations to current mental health care standards for paramedics.

Braedley (2010) states that there has been substantial redistribution to health care in Canada since the advent of neoliberal governance. Following the questions of *who* is providing care, *where*, and what does that care look like, she explores shifts in care provision that have occurred in unexpected settings. With the case of firefighters increasingly being called to health care calls rather than appropriately designated fire calls, and potentially providing a kind of care which has traditionally been vastly outside of their function, scope and training. She describes this redistribution of healthcare to a public service not previously designed or trained as such, ‘accidental health care,’ and traces this shift to the advent of neoliberal governance in Canada (Braedley, 2010). To what extent are neoliberal policy contexts producing unexpected outcomes as a result of paramedics providing an increasing amount of mental health and psychosocial support in the community?

5.4.3 (a) ‘Accidental’ care: 9-1-1 care filling the gaps

In questioning whether paramedics are the appropriate service to fill gaps in mental health care, it is necessary also to look at what other emergency services may be filling care

gaps. Here I explore the role of emergency services filling care gaps and how these shifts have come about.

Individuals with mental health needs are often described as ‘inappropriate’ users of paramedic services or a ‘burden’ on the system (Campbell & Rasmussen, 2012; Cuddeback et al., 2010; Larkin et al., 2006; Prener & Lincoln, 2015). This depiction of inappropriate use drives the question of what then, is the appropriate service or resource for these individuals. Given the biomedical origins of paramedic services, with a focus on acute medical and traumatic emergencies, the training and work is not based in mental health and psychosocial care (Brady, 2012). This is reflected in the policies guiding paramedic practice – the *BLS PCS* (2018) and the *ALS PCS* (2018), which provide minimal guidance at best with regard to management of these types of calls, and at worst, frame these calls as solely safety concerns for violent patients encountered by paramedic services. Furthermore, policy around transportation of patients by paramedic services exists largely in the framework of transportation of individuals with acute medical and traumatic emergencies, with limited focus on the most appropriate destination, and challenges for putting this into practice. Despite the shift in thinking and care provision that has been and continues to be required by paramedic services to manage mental health and psychosocial calls (Brady, 2012), these needs in the community appear strong and the calls continue to arrive, despite whether paramedic services are training in other methods of care.

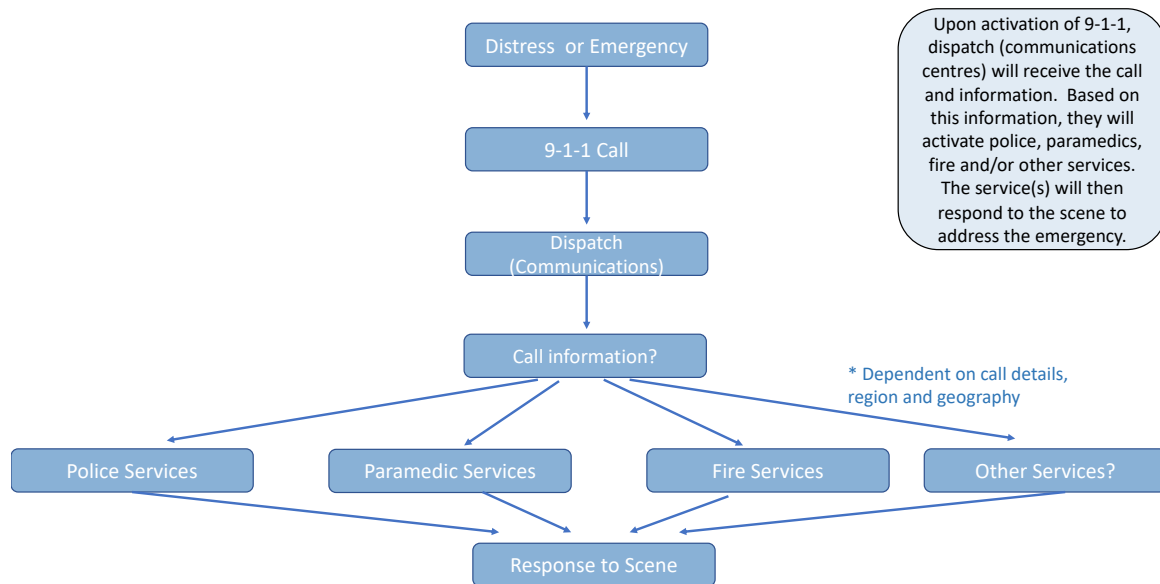
In its current form, paramedic services may not be the ideal service to manage these calls. It seems however they are in many cases the only resource available or at least accessible. Individuals activating paramedic services for mental health needs are making the decision to activate these services within the constraints of other system limitations, and with nowhere else to turn. By the same token, paramedics responding to these calls, are constrained by the standards and policies that direct their practice, or in some cases a lack of guidelines to support their practice and care in this area.

The increased use of ED services in Ontario for individuals with mental health needs has remained unexplored (Annual Report of the Office of the Auditor General, 2016), and similarly there are no formally documented findings indicating reasons for increased use of paramedic services for individuals with mental health needs. Mental health needs may increase with deinstitutionalization, the downloading of mental health care onto communities and community agencies without parallel funding support, as well as the general retrenchment of welfare state

supports which support and maintain good mental health. ‘Accidental health care’ provision (Braedley, 2010) occurs when care is provided by unexpected, publicly funded agencies resulting from neoliberal policy shifts. Paramedics cited their perceptions of the reasons for their mental health calls as: the closure of large mental health institutions or facilities; too few community mental health supports; and unsupported individuals who “don’t know where else to turn.”

How has increased use of paramedic services to manage mental health and psychosocial emergencies been impacted by mental health and social policy change? Deinstitutionalization, while in many ways a positive change for individuals struggling with mental health, has shifted care responsibilities away from the state and into private spheres, creating a diffuse system of social and mental health supports (Hartford, Schrecker, Wiktorowicz, Hoch, & Sharp, 2003; LeFrançois et al., 2013; Morrow, 2013; Morrow, 2017). Given the variation in what supports exist such as community mental health agencies, hospitals, or specialized psychiatric hospitals or other physician’s services (Annual Report of the Office of the Auditor General of Ontario, 2016) and the challenges in navigating the system, the needs of many individuals have not been met, resulting in distress and sometimes crisis (Wiktorowicz, 2005). As a result, paramedic services have been one of the services filling gaps, despite their limitations.

Figure 5.3. 9-1-1 services activation



Gaps in mental health and psychosocial care systems have shifted the ways in which emergency services are activated and used. Figure 5.3 illustrates the response to 9-1-1 distress calls, and the multiple services that may respond to a call. When 9-1-1 is called, dispatch (the communications centre) takes the details and determines which services will respond. This exact process is variable by region, and service availability or response is also dependent on the call details, the region and geography. Ultimately, dependent on the call information received, it is possible that paramedics, police, firefighters and/or other services (to be further discussed in Chapter 9) may respond to a scene.

Most commonly, paramedics and/or police would be the responders for mental calls. Firefighters may be present for some, typically brief period of time on the scene of calls related to mental health depending on the call details. Any response from fire services to these calls is due to the fact that they are dispatched to a larger number of paramedic calls than previously (Braedley, 2010). Calls to which fire services are typically tiered with paramedics, other than fire calls, include motor vehicle collisions, shortness of breath, unconscious or cardiac arrest calls or other complex extrication calls. Braedley (2010) identifies fire fighters' increased response to "medical" calls as a result of a relatively inactive labour force due to the advent of enhanced fire prevention and fewer fires to fight; the advocacy of insurance companies requiring fire services to be readily available to protect capital interest; and the dominant social and political role of typically white, male dominated, masculine fire services. This has resulted in a readily available workforce with far fewer fire calls to attend to, and the opportunity to fill a gap in emergency medical response where paramedic services are largely overtaxed and understaffed (Braedley, 2010). Evidence is lacking however for the utility of fire services in medical care provision on calls for emergency medical needs. In the case of a medical call, ultimately paramedics are always sent as the primary care provider on these calls even if fire is dispatched. Paramedics are responsible for all assessments, determining patient care and transporting the patient to hospital. In the case of mental health or psychosocial calls, typically, firefighters would be cleared from the call by paramedics relatively soon after paramedics arrive on scene as their services (ie: fire fighting, assisting with patient extrication or equipment movement, or assisting in performance of CPR) is not usually required on such calls. The role of firefighters on mental health and psychosocial calls was discussed minimally by paramedics in this study, other than paramedics stating that too many responders on scene often aggravated the situation.

Emergency response for individuals with mental health needs also exists beyond paramedic services with police services. Heslop et al. (2004) note that since the 1960s, there has been increased contact between individuals with mental health concerns and the police, frequently resulting in arrest or apprehension (Heslop, Stitt & Hoch, 2004). Cotton & Coleman (2010) identified that as of the 1980s, Canadian police experienced increased responses to individuals with mental health concerns and a need for a system's approach to addressing these types of calls, including social services and mental health services. Police involvement with people with mental health concerns have been seen by some as a failure of the mental health system (ibid).

To address this increase, police services have developed programs such as Crisis Intervention Teams (Canada, Angell & Watson, 2012; Cotton & Coleman, 2010; Franz & Borum, 2010), a designated mental health officer, mobile crisis teams, and more comprehensive models which may involve other mental health and social services (Cotton & Coleman, 2010) (some of these programs will be discussed in Chapter 9). While improvements in the comprehensiveness and preventative role of police response for individuals with mental health needs have occurred (Vaughan et al., 2018), challenges remain around funding, variability in response depending on geographical location, and substantial questions remain about the appropriateness of police as a central service interacting with individuals with mental health needs (Cotton & Coleman, 2010). As Wiktorowicz (2005) identified, increased pressures on police and correctional services have been an outcome of poorly integrated and coordinated mental health services in the community. This increased demand for mental health related care from police services aligns also with the demand paramedic services are facing. Given the increased demand from both police and paramedic services for these calls, management of these calls comes from both services (further discussed in Chapter 6) and some collaborative programming between the two to manage these calls (as will be discussed in Chapter 9).

These changes to service demand and scope of care provided by emergency services raise important questions about the appropriateness of their response for mental health or psychosocial crises, the gaps concealed by their response to these calls, and the ways in which funding and resources are provided to different services with varying degrees of responsibility for care of individuals with mental health needs. Increased funding in acute care services (Braedley, 2010) versus preventative, community mental health services, or social services likely will not address

the increased care needs that are arising and being directed to acute or emergency care services. The use of multiple emergency services being dispatched to a mental health emergency also presents questions about appropriateness, utility and cost of services and how else might gaps in care be better filled.

Along with gaps in community mental health and crisis services, social and economic policies and structures have implications for individuals' wellbeing (Allen, Balfour, Bell & Marmot, 2014; Fisher & Baum, 2010). Neoliberal policies impacting determinants of health such as employment, housing, food security, neighbourhoods, gender, racialization and a range of other factors, have the potential to create very real distress for individuals in a range of circumstances. Social inequities in many of these areas are "intimately tied" to distress (Morrow, 2013) and experiences such as living in poverty, and experiences of systemic racism create conditions in which distress is a very reasonable response (Mills, 2015). Additionally, such policies result in unmet needs such as insufficient supports for chronic conditions and care received at home, in the community rather than in publicly funded institutions (Dyck et al., 2005; Milligan & Power, 2009), also driving some of the broader psychosocial calls, where individuals do not know where else to turn.

Paramedic services along with other emergency services – in particular with police, have experienced a shift in demand for care from traditional domains of acute medical and traumatic health emergencies to the domain of mental health and psychosocial care (Brady, 2012), and it appears much of this demand has come as paramedic services fill the gaps in other service domains such as appropriate, accessible community mental health services. Critique of whether paramedic services is the 'right' service for these types of calls or whether these calls are an 'appropriate' use of paramedic services draws attention to policies and systems outside of paramedicine that impact the occurrence of these calls.

5.4.3 (b) Paramedicine standards guiding mental health care

Despite the discussions of 'appropriateness' of using paramedic services for mental health calls, paramedics do attend to these calls, yet paramedic practice in Ontario receive minimal guidelines around mental health or psychosocial care. These limited guidelines and standards, intended to direct how patient care is delivered by paramedics present two particular concerns. The first is about the lack of direction for care provision, begging the question of how

exactly this care is carried out by paramedics in Ontario with such minimal guidance. The second issue lies in the dominant narrative and framing of these calls in the Mental Health Standard of the *BLS PCS* (2018), which defines patients primarily as violent and aggressive. The disclaimer provided in the guidelines is that these standards may sometimes be insufficient for clinical care or practice and that paramedics are to use all of their skills and training to manage calls in the most appropriate way. While this suggests that there may be further information, tools or skills carried out in paramedic practice in the area of mental health and psychosocial calls, this does present concern for the degree of uniformity and standard of care provided in this area.

5.5 Conclusion

Mental health and psychosocial calls in paramedicine are situated in the context of paramedic, mental health, social, and economic policies and guidelines. Within paramedicine, standards of care offer limited guidance in providing mental health and psychosocial care and policy further limits the care paramedics are able to provide in transporting patients.

The biomedical, acute care origins of paramedicine appear reflected in the policies guiding paramedic practice and require further examination and evolution to keep up with demands for this type of care in paramedicine in a comprehensive way, upheld to an appropriate standard of care. Training and education in this area of paramedicine will be explored in Chapter 8: Training and Education. Furthermore, the narrative of patients with mental health concerns framed as violent and aggressive will be addressed further in Chapter 7: Care on the Front Lines, section 7.5.1.

Beyond paramedicine, the process of deinstitutionalization in combination with insufficient community mental health services has likely increased the volume and frequency of mental health and psychosocial calls to paramedic services. Gaps in these services and lack of continuity in mental health care and community supports contribute to individuals reaching a point of crisis with few other options beyond 9-1-1. Neoliberal ideologies shaping these policies problematically shift costs into private domains and responsabilize individuals and families for support, maintenance and care of mental health and wellbeing. These policy issues, associated with negatively impacted determinants of mental health have the ability to lead to distress and

worse mental health for individuals, potentially resulting in calls to emergency, acute care services, including paramedic services where other supports are lacking.

Individuals seeking support from paramedic services are doing so within the constraints of the mental health and broader systems in the community and the paramedics providing this care are working within the constraints of the current system to do so. Paramedic services may not be the ideal option for this care provision, and ultimately may not be the right service. At this time however, they along with police services appear to be filling gaps created by the process of deinstitutionalization, lacking or poorly integrated community mental health services, and neoliberal influence in other areas of social policy, impacting the social determinants.

Chapter 6: Care on the Front Lines

6.0 Introduction

The description below of the start of a call is one snapshot of what care on the front lines can look like for paramedics - complex, dynamic, and full of uncertainty. A situation that seems dramatic and out of the ordinary for many, is a regular day on the job for paramedics.

We weren't in the station too much longer before our crew got a call. The call came in with the details: 21-year-old male self-inflicted injury to arm, bleeding controlled, police also dispatched. We would be met in the lobby. Code 3 (urgent, but not lights and sirens). When we arrived scene, police were not there. As we exited the truck, we went up a set of stairs and were not met in the lobby – the crew radioed to dispatch that we had not been met and noted police were not there. The crew said they would knock on the door and if there was anything “off,” we would go and wait somewhere else. Given that the details involved a self-inflicted wound, the reality is that there could be a weapon on scene and we do not know any more details than that. Someone answered the door, the crew entered and left the door propped open. As we entered the apartment it smelled strongly of smoke and there were cigarettes still burning. I could hear voices down the apartment hallway. The two paramedics entered toward the patient, I waited behind them, close to the door. The woman asked if we would close the door – one of the medics said, no, we're going to leave it open. I understood she did this so we would have a point of egress, given that this seemed to be a bit of an uncertain situation.

(Field Notes, 2017)

Chapter 4 explores the various types of mental health and psychosocial calls paramedics encounter. Chapter 5 presents the guidelines and policies for paramedic practice. This chapter provides a descriptive account of the ways in which care is provided on these calls and explores the ways in which guidelines are put into practice. It draws on interviews with front line paramedics and paramedic services management, and observation of calls within different paramedic services in Ontario.

In terms of organization, Section 6.1 describes the different stages of the care process for paramedics attending to mental health or psychosocial calls from dispatch through to offloading the patient. In Section 6.2, I present how paramedics manage mental health and psychosocial

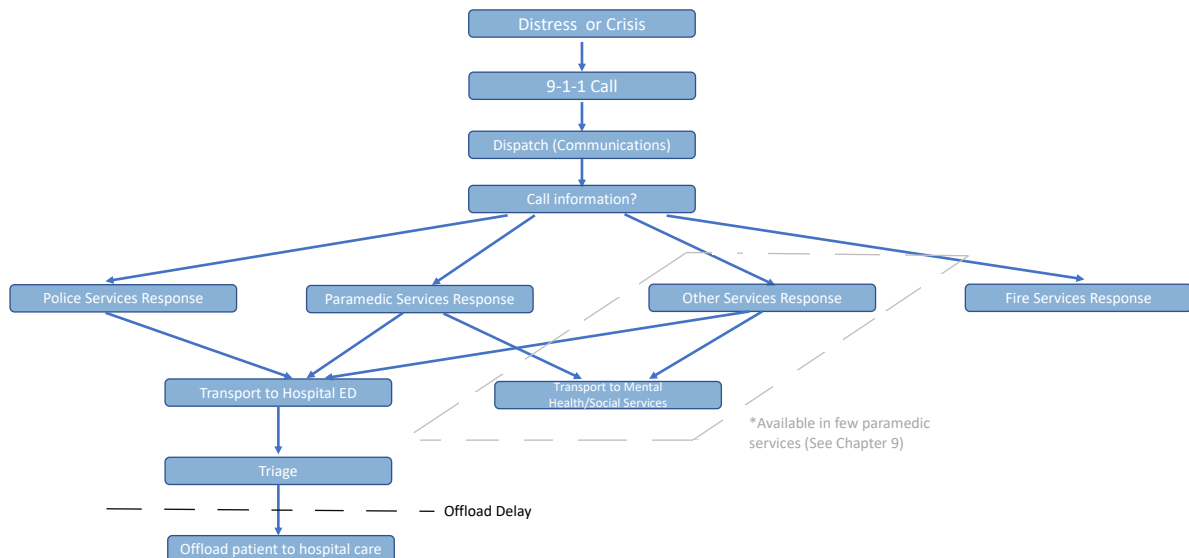
calls including communication, the importance of team work with partners and other allied resources on scene, and the need to address safety and violence.

The findings in this chapter support those presented in Chapter 5 – there is little or no standardization of the way assessments and care are provided. It demonstrates that it is necessary to explore both the challenges of care provision within certain system constraints as well as the constructive and seemingly positive ways in which care is provided by paramedics in this setting to better understand how paramedics are managing well and the areas where challenges exist. This descriptive chapter lays the groundwork for Chapter 7, which identifies key themes in terms of challenges for both care providers and care recipients, and discusses the ways in which certain contexts and conditions may either support or limit the care paramedics are able to provide for individuals with mental health needs.

6.1 The stages of a mental health call

The stages of the care process for those with mental health concerns begin at the point of receiving call information from dispatch, followed by arrival on scene, transportation to hospital, and finally triaging and offloading the patient at hospital.

Figure 6.1 How does a person with mental health needs get to the hospital ED in Ontario?



At each stage, I will describe the ways paramedics manage mental health calls, the skills and methods they put into practice as well as their language regarding this management. An individual's call to paramedic services involves multiple different services (i.e. dispatch, allied resources such as police, the receiving facility staff in the ED) and social structures. I present the challenges that paramedics identify at each of the different stages of this process and the importance of the interaction among others involved in care on these calls.

Attending to a call is a process that is dynamic with multiple stages. Although each call is unique due to both the call type and context it emerges from, paramedics face a fairly consistent structure with some variations contingent on the paramedic services and/or region from which the call originates. I will outline the process of a call as it is typically experienced by paramedics in Ontario, informed by my interviews with paramedics and paramedic services management as well as my field observations. While there is variation, particularly in remote regions of Ontario, this was the structure in the services in which I observed as well as where I have worked and attended calls both professionally and as a student. I will refer to how the call process proceeds on a primarily mental health related call and using terminology common amongst paramedics, as four distinct but related stages expanded upon below: 1) Receiving the call from dispatch; 2) On scene arrival and interaction; 3) Extrication of the patient from scene and transportation to hospital; and 4) Arrival at hospital and triaging of the patient, which includes a possible period of offload delay, and transferring care of the patient.

6.1.1 Receiving the call from dispatch

Paramedics must first be notified that they have received a call. If they are in a station, they may be notified by “tones” going off on a speaker system, and a short message indicating that there is a call, and the priority of the call. These tones vary somewhat from service to service. They are usually a jarring sound, or a “jolt” that can make you jump particularly if you have been in a station with a little bit of downtime. If paramedics are in their ambulance, they are notified by the main radio in the truck, as dispatch calls for their truck number over the air, stating they have a call for them, and what is the priority of the call. If they are otherwise out of the truck but not in the station, for example at a hospital or making a stop somewhere, they are notified by their portable radio. Once the paramedic “books on” the air, it means that they have notified dispatch they are ready to take the call. In some services, certain parts of this process

may be undertaken via a pager, cell phone or computer where buttons are pressed to acknowledge a call, in order to convey that they are ready to service a call. At this point, paramedics are given the details of the call, indicating the priority level (or degree of urgency) as per dispatch, a descriptor that varies by the dispatch system and region, the location, and whatever details they are able to provide at that time.

Paramedics identified that the information dispatchers have and are able to provide is often limited, and may or may not reflect what the call itself will look like. One paramedic stated the importance of not focusing heavily on the dispatch details as they may be significantly different to what is actually happening on scene:

I think that's with all calls, not relying necessarily on dispatch's information. Sort of turning that...turning that off, and just looking at things fresh when you go in...there could be a mental health component that you haven't really looked at.

(Front-line paramedic: Interview 011, 2018)

With regard to mental health or psychosocial calls, paramedics acknowledged that the details may or may not be informative about the mental health-related nature of a call. They drew attention to information that could be particularly relevant from dispatch, specifically with regard to safety and potential threats on scene. Paramedics described the act of “staging,” something done when it is identified that there is an assailant or weapon on the scene, or other potential threats to the paramedics. Staging means that the paramedics follow a particular protocol laid out by their service and wait near the call, but do not actually arrive on scene while they wait for further information or for police to arrive. While dispatch may indicate paramedics are to stage if they have particular details, the decision to stage is otherwise at a paramedic's discretion. Staging takes the safety of the paramedics and other responders into account, and may result in delays in arriving to the patient on scene.

This initial period of gaining information about the call, to arriving to the scene of a call establishes the interactions between paramedics and the patient. Additionally, paramedics indicated that the location of the call, prior experience in that area, and other information from allied resources such as police provides insights into what they may be encountering on a call. While paramedics discuss not wanting to have “tunnel vision,” with regard to what a call may

entail and wanting to look at things fresh when they go on, it is clear that at times, this prior information informs at least some of the paramedic's view of what to expect.

6.1.2 On scene with mental health calls

As discussed in Chapter 4, there are a wide range of calls paramedics attend to that may be described as mental health or psychosocially-related. In this section I will not attempt to describe any one type of mental health call that paramedics respond to, but rather the ways in which they describe their management of mental health calls as a whole and what care provision may look like on the scene of these calls. First and foremost, different paramedics described unique approaches without one single structure or method to managing these calls. Paramedics described still having to address and rule out the possible medical aspect of mental health calls by performing vital signs and assessing the patient's physical state. In the case of an overdose or traumatic injury they have protocols to follow to manage these physical concerns, but from there, the care provided with regard to managing their mental health or distress varies.

When asked how paramedics manage mental health calls, one paramedic responded in this way:

Uh, on your own. Your best, best practice is really all you can do. Your best decision making at the time...And it's...there's no cookie cutter syllabus on how to handle a mental health patient in our field...And it would be nice to have one but there's not really a medical directive... no I don't think you could.

(Front-line paramedic: Interview 014, 2018)

No, you really fly by the seat of the, your pants. It really just depends on how the patient is presenting to you.

(Front-line paramedic: Interview 015, 2018)

The ways paramedics discuss managing mental health and psychosocial calls on scene, will be expanded upon in section 6.2.

6.1.3 Transportation – From scene to hospital

If the patient comes under the care of paramedics and a decision has been made for a patient to go to hospital in the care of paramedics, they will be transported in an ambulance. This could be lying on the stretcher, or sitting in the jumpseat, depending on the circumstances. While there is some variation by paramedic service, typically, paramedics are required to transport patients to the nearest hospital, and this includes patients with mental health needs. Alternate destination options and potential recommendations regarding these scenarios is in Chapter 9. During transport and depending on their given concern or complaint, paramedics can provide ongoing care to patients such as ongoing emotional support, monitoring vital signs, or medication administration if indicated. With mental health calls, some paramedics stated it simply feels like a ride to the hospital because there is often little active, ongoing care that is provided en route.

So for us, the ideal would be we could take them where they need to be...but other than that, what we can do for them...nothing. We are...we are a taxi cab, in those circumstances.

(Interview 003, 2018)

6.1.4 At hospital

When patients arrive at hospital, paramedics begin the process of triage, which involves providing a report to a triage nurse who then assigns the patient a priority and an in-hospital destination. The triage process and the offload process, which are often accompanied by an “offload delay” means that the patient remains in the paramedics’ care and on their stretcher until a bed is available. Paramedics described unique challenges with the triage and offloading processes that are specific to mental health calls. In particular, paramedics identified how mental health calls do not take priority in the ED, the frustration from hospital staff with repeat users, as well as the challenges for patients in distress waiting for extended periods in poor conditions over multiple engagements in these processes.

6.1.5 Triage

Upon arrival at the ED, every patient must first be triaged, to determine the acuity and priority for assessment and treatment, and this is also the case for patients arriving by ambulance. It is a common misconception that patients will be seen more quickly by ambulance, however all

patients go through this same triage process, regardless of the way they arrived at hospital. Additionally, patients must be registered. Paramedics provide a report to the triage nurse describing the current complaint and situation, patients' medical history and any assessments and care provided by paramedics.

While theoretically this is a transition in care where information is simply being provided from one care provider to another, paramedics identified challenges in this process, and concerns for how this process translates into care for the individual in distress in an emergency department generally designed for medical and traumatic emergencies. One paramedic aptly described the challenges of arriving at hospital and interacting with the hospital staff for both parties:

So usually what happens is, we come in the doors, we go to the registration area, register with the clerk and if it's a familiar patient they'll roll their eyes, if it's an unfamiliar patient they'll take all the information and they'll ask what the problem is. And then we go and do the triage with the nurse for them to define the acuity or the severity or whatever the issue is with the patient. So, another problem is that at {name of hospital}, the nurses there are very burnt out unfortunately. I love them to pieces but they're just tired. 'Cause they're understaffed, they're underfunded and they're overworked. And they deal with mental health non-stop and it's very draining to go, to do an entire 12-hour shift, go home, sleep, come back in and either see the same patient or have the same patient come back in, or have another patient that presents similarly and it's just this nonstop, emotionally draining experience. So...they'll roll their eyes (*laughs*), depending on what the problem is. And then they'll kind of ask me like, you know "do you think this patient needs to be watched, do they not need to be watched." Usually I tend to advocate for the patient. I have some people that I work with that, they just want to get out of the hospital and they don't want to be sitting on delay for six hours so they'll be like "oh yeah this patient can be left alone" and it's probably somebody that shouldn't be...Sometimes if they're regulars they just get sent to the front area of the waiting room. Uh, and then a lot of times if they're like consistent regulars ...they'll just walk out of the front door and then leave. 'Cause they basically just wanted somebody to care for ten minutes, kind of thing...

(Front-line paramedic: Interview 002, 2017)

The paramedic went on to describe situations that have occurred in the past when a person had arrived with a mental health issue and was left unattended. While unattended, the patient

overdosed on their medications and ultimately died. As a result, the paramedic noted that EDs are “on high alert”, and are more likely monitoring people experiencing mental health distress.

6.1.6 Offloading – Transferring care from paramedics to hospital

Following triage, paramedics are directed to transfer care to the hospital by “offloading” the patient to the waiting room or to a hospital bed. If there is no bed available and the patient requires ongoing care the paramedics go on ‘offload delay’, which may involve waiting anywhere from minutes to many hours, or even being relieved by the crew on the next shift, who will continue to wait at hospital, but ultimately this varies by region, hospital and by day. Offload delays may occur for any number of patient conditions, including mental health needs.

Whether patients are assigned to offload delay accompanied by paramedics, or are offloaded to the care of the ED, paramedics described how patients often wait alone on hospital beds that are lining the hallways, or are left to wait in seclusion rooms. Paramedics identified particular challenges experienced by individuals with mental health needs waiting under these circumstances. The main challenge identified is that generally speaking, patients must wait in the midst of the ED, a space that is often noisy and chaotic for any patient, particularly someone in emotional distress.

There was one, this woman. She hadn't quite dealt with the grief after losing a son years ago. Six-seven years ago. So she often will go through these episodes where she's in inconsolable grief. And the family's like, oh she's doing this again. And you know, sitting in the emerg, in the hallway, on a bed, crying. Going through grief that is very real for her, in front of all these like, crack heads, and sick people, and...that's not, that's not healthy for her, that's not healthy for everybody else.

(Front-line paramedic: Interview 001, 2017)

Wait-times experienced by patients with mental health needs in EDs evidently vary by region and by hospital. In a range of regions within Ontario, both rural and urban, paramedics described accompanying patients typically waiting for extended periods, either on offload delay, or after care has been transferred to the hospital. In one urban centre, paramedics described a hospital that receives a high volume of patients with mental health needs. Paramedics describe

hospital beds lining the hallways of the ED, typically with security guards standing by to monitor patients.

When I go to {name of hospital} which is our mental health hospital, and the majority of their admits are mental health! And they're {mental health patients} lining the back halls. They put up like partition curtains...in...literally it's a hallway and they block it off. And people are just lying bed to bed to bed to bed...hiding them.

(Front-line paramedic: Interview 001, 2017)

Additionally, for those assigned a room, paramedics identified the conditions within which they wait: often in seclusion rooms, sometimes with a restraint bed or in a room with nothing in it.

So right now we take people to {name of hospital} and then they have like a hallway with maybe like six bedrooms...where they can put mental health patients, but it's like restraint beds and the little fish bubble eye on the door. Like it's not a welcoming place... I don't know the logistics behind it but I mean I think it would be great for somebody with a mental health issue to not be shoved into a back hallway for twelve hours, right? Just to sit and wait for maybe nothing to happen, 'Cause I'm sure that would be discouraging and they're not going to want to go back after that right?

(Front-line paramedic: Interview 004, 2017)

Consistent with this paramedic's experience, paramedics who discussed the on-scene challenges of convincing or encouraging individuals to come to hospital spoke to the issue of individuals being unwilling to be transported when they knew the conditions and circumstances of waiting in the ED (ie: long wait, seclusion rooms, lack of support while waiting, and a sense that they may leave without getting the help they need). These were identified as key challenges in managing mental health related calls. Paramedics are unable to change the location of where a patient is assigned and note how these circumstances can increase the agitation and reluctance of individuals on the scene to receive support as well as have paramedics transport them to ED in the first place. The challenges associated with the ED as the receiving location for individuals with mental health needs are presented further in Chapter 7.

This section outlined the stages of care from the dispatch of a call, through to the offloading of a patient to the care of the hospital. The subsequent section describes how paramedics manage these types of calls, and highlight the challenges that exist for both paramedics as well as individuals in distress.

6.2 Managing mental health calls

Other than the need to ensure that the medical and physiological possibilities have been addressed or considered, paramedics state that there is substantial variation in the ways that these calls are managed. I have categorized the topics paramedics discussed regarding mental health call management on scene into three main themes: communication as the main tool and means of managing these calls, including ways of approaching individuals with body language, tone of voice, and words used; the importance of team work, and the role and interactions with other people and resources on scene, including the importance of their partner, other allied resources such as police, and bystanders on scene; and safety and threats of violence.

6.2.1 Effective communication and challenges

Paramedics discussed how their demeanour, ways of approaching an individual, and style of communication are the most significant ways of managing a mental health call. While there is no set medical directive, no medication to be administered nor procedure to be followed, often speaking to and listening to the individual in distress is how care is provided and the main tool paramedics have to manage these calls. In describing communication, they often referred to the importance of speaking to people with respect and compassion and working to gain the individual's trust and build rapport.

And I've never even met the person before. So, in that initial, patient contact that we go through, the first thing is trying to...I don't want to say befriend, but at least gain enough trust with the person that they can answer some very, very simple questions such as do you know the medications you're on, do you know the medications you're supposed to be on? Do you have any diagnosed medical conditions? Do you have any allergies to any medications? Where's some identification, a health card, or driver's license so I know who I'm speaking to here? If you can, at least get to, that...portion of trust, where you can then explain ok, you called because you want assistance, what assistance do you want? You know, I, I want to go to the hospital

and I want to get my prescription refilled. I want to go to the hospital and I want to go to the hospital and get them to take this chip out of my body. There's many different things...If we can both come to agree that you want to go to the hospital, you called for somebody to take you to the hospital, I'm going, I'm quite willing to take you to the hospital and I can get you to the assistance that I think you need, or at least take you to the place where you think you're going to get the assistance that you want and require. Then, we can get going in that direction.

(Front-line paramedic: Interview 005, 2017)

Typically, we just try to use our words and try to develop and establish a relationship of trust with the patient. We try to appear non-threatening and we always emphasize that we're there to help, there to listen, there to support them and advocate for them. Then we always suggest going into the hospital in case there's a background medical problem that could be causing them to act in this way or feel this way or something like that.

(Front-line paramedic: Interview 025, 2018)

On mental health-related calls paramedics spoke of compassion and being non-judgmental as not only what they felt was the right thing to do, but also as being critical for a call to go more effectively, and to make it more likely that the person will be receptive to receiving further care and help.

So...I would go in and, just, I always just try and speak kindly and gently and understanding. I try and not be judgmental...Just, I try and, mostly just be kind and compassionate 'cause I think that's probably the most important for these people, and then bring them to the professionals who...I don't, I don't pry or ask too many questions because, a lot of it really just isn't my business...I think the role, I think minimum we need to be kind to these people, that's really important to me. I think that just has to be...that's our job.

(Front-line paramedic: Interview 006, 2017)

Paramedics also identified their own physical body language and their ways of approaching an individual as key elements of their communication on these calls.

Good communication and getting at their level...Always maintaining eye contact. Submissive posturing, so I'm not looking above them or below them but get at their

level rather than standing above them. Never getting too close (laughs), 'cause you don't want to, like yeah...and I always try to kind of get them to cooperate first rather than having the cops come.

(Front-line paramedic: Interview 014, 2018)

Additionally, patience and good listening skills were identified by paramedics as critical skills for positively managing these calls. They discussed listening and patience as necessary both for building trust, as well as for obtaining necessary information to manage and move forward with the calls.

...the less you say, and the more you listen, the better the call will go. And just thinking about what you say and how you're gonna articulate a question and, do you actually need to obtain that information, or is it just agitating, so...listening and then also being fully present and aware of the reactions and the demeanor of the patient...you don't want to push them too far, and is there a point to doing that or not, right?

(Front-line paramedic: Interview 022, 2018)

One that I can just kind of think of right off the bat of a tool, is that sometimes people speak too much when they're speaking to mental health patients and don't listen enough, so I try to establish trust and understanding without being overbearing and still trying to get the words out of them about what happened and how they're feeling and stuff like that.

(Front-line paramedic: Interview 025, 2018)

Along with building trust and obtaining information from their patient, paramedics identified that being able to calm patients was necessary and a variety of communication strategies may be needed. Particular communication techniques such as distraction or sometimes humour were identified as means of getting the patient to calm down and be able to determine what the next steps on the call might be.

Uh, some people are really good at distraction...And they can talk to the patient and distract them from what's going on and then go back around to it, and then get them to calmer. And then they can communicate what's going on and what we need to do for them...I'm really good at calming patients, I can talk to patients and get them to

look at me, and I get the right voice and I'm really good with that. I can get a patient to calm down fairly quickly and... get them thinking in the right direction, ok this is what we need to do, and go from there. I mean there's nothing medically we can do for them, other than get them to the hospital and have them treated so...The idea is to keep them calm, and to find out what they've done, if they've made a plan or if they've tried to implement that plan, and those types of things.

(Front-line paramedic: Interview 015, 2018)

Paramedics also acknowledged their own frustration, but that it is necessary to communicate and interact with patience, no matter how trying the circumstances.

I mean it really depends on the medic, but you know, for me... it's all across the board. But for me, I try to be patient. Like, that's the first thing. 'Cause you know, at three in the morning it's really difficult, when you've got...you've got, you know a frequent flyer who's calling you up, and you know sure as shit that they just, you know, that they're just drug seeking or, you know, whatever, it's... it's not something and they've waited 'til three in the morning, they could have called me at three in the afternoon. So patience is the biggest thing. And you know, I struggle with it too, you know, everybody does. But I think that's the first key, is walking in there with an open mind and patience

(Front-line paramedic: Interview 016, 2018)

Along with the acknowledgment of the positive ways of interacting and communicating to make calls run smoothly, paramedics identified that there are less compassionate and more abrasive approaches to managing these calls. Many paramedics state that as a whole, they felt that there is room for improvement in the ways that paramedics manage mental health calls, and in some cases improvement in the way that patients are treated on these calls. When I asked one paramedic to tell me about the ways paramedics manage mental health calls, his response was, "Not adequately (laughs)" (Interview 002, 2017). Other paramedics suggested that many paramedics respond in frustration, or don't take the call seriously.

There's like a whole spectrum there, I think there's like, they're dealt with very poorly by some. Like some people... just get very frustrated or sort of roll their eyes, or on the way to the call we'll know who it is and already start talking about how

this is a joke and you know, this and that, and then there's people who just have hearts of gold and...and really want to help.

(Front-line paramedic: Interview 004, 2017)

Paramedics identified that there is occasionally a sentiment that because these calls cannot be refused by paramedics even though there is not a 'real' emergency, that this sentiment can be conveyed in the way that calls are managed.

I've seen cynicism too. ...I don't know if the language was used that...like this isn't a real call, or, you know, this person just utilized the service that somebody else could have used. That's...I would say that's the minority

(Front-line paramedic: Interview 017, 2018)

Whatever's going on with them, it's their worst day, and we have to try to be a link in making them better, but they know that it's not going to happen right then and there. It's going to be a process, I think. And it's—some people, like it's kind of hard for them to see that, and I think we as paramedics can, unfortunately sometimes just brush them off...and kind of be like, just get in the truck, your life's not that bad, you know? We just came from—whatever, like a—a child hit by a car, I'm just—right? So your life really is not that bad. You're 50 years old, living in a beautiful home, get your butt in that... get your butt in that vehicle and we'll get you to the hospital, right?

(Front-line paramedic: Interview 019, 2018)

Many paramedics spoke of recognizing the need to be patient and understanding, which makes calls run more smoothly, but many identified these frustrations and feelings that complaints on some of mental health calls were not as valid as medical or trauma calls.

Along with patience, paramedics indicated that the actual style of communicating and tone of voice of paramedics on scene may not be appropriate or constructive for interacting with people in distress or crisis.

I've seen guys go in and they get real barky and loud and, and aggressive toward a person and I...Oooh...like we don't need that, that's just going to make things a whole lot worse. And nine times out of ten it does right?... But I always feel like,

you've kinda gotta have a soft, not a baby tone or talk to them like they're an idiot or somethin' but just talk to them, and listen to 'em, and...somethin' the wife and I decided a hundred years ago was that...God gave us two ears and one mouth right? So you listen twice as much as you talk.

(Front-line paramedic: Interview 009, 2018)

Another cause of negative communication identified by paramedics is frustration at repeat callers, often termed 'frequent flyers.'

Because it's easier to say, "Oh, this person's shitty, I'm going to treat them shitty." That's not going to help the situation at all, so I really think that going in without any biases or understanding that it's out of their control would help a lot with patient care...Going in there and saying, "Okay, what's wrong," or having the attitude like nothing's really wrong and they're just pretending. Like, I get it. Some medics have seen this before and they've maybe encountered this patient before but it doesn't mean it's not a cry for help. Going in with biases or thinking that they don't really need help doesn't help the situation at all. It makes it worse and the patient doesn't want to talk you, they don't want to... they're not forthcoming with their actual problems. They're kind of more roundabout with answers.

(Front-line paramedic: Interview 027, 2018)

6.2.2 Working in a partnership: skills and dynamics

Paramedics providing care on the front lines requires team work, and interacting with partners on the scene of a call. Paramedics described how they managed and provided care on mental health calls, and I observed this during my observation shifts as well. Paramedics referred to the role of their partner and of the integral role that they may play in providing support and moving the call forward in constructive ways, as well as the challenges that they may present.

Except for the case of first response units or a supervisor, both of whom are in single occupant vehicles, which are a minority of vehicles, paramedics consistently work in a partnership. Paramedics spoke of their partners as important for many aspects of their job and for whether their shift is enjoyable or not, but consistently highlighted that their partner was sometimes one of the best resources they had in managing a mental health call. In particular, in

more rural or remote areas, paramedics found their partner to be crucial as they may have a very lengthy wait before they have any other available resources to assist with the call.

Paramedics often referred to partners as something that can “make or break their shift,” because you are in the truck and station with them for twelve hours, and they are the person with whom you count on to “have your back” on a call. At times they spoke of a good partner as one who complimented their own style and skillset, or who had the ability to read them and know when it was their turn to step in and manage a situation. Others spoke of knowing that they themselves were impatient and lacked the skills to deal effectively with mental health calls, and explained how their partner’s patience and aptitude for those types of calls was critical. One paramedic spoke of a challenging mental health call where there was a situation that escalated quickly with an extremely agitated patient. She said that while these calls are relatively infrequent, the right partner played a substantial role in managing the situation:

Oh, huge—having a good partner is huge. As a matter of fact, in that particular situation, I can honestly say that without my partner, that whole situation, oh—I—yeah, it—it could have—it would have gotten resolved...but to have it resolved as efficiently, quickly, and—and correctly as it was, it would have definitely not had as good a result as it did.

(Front-line paramedic: Interview 020, 2018)

In one region in Ontario, a paramedic pointed out that it sometimes made a difference if one partner was Anglophone or Francophone when managing certain calls, and they felt there was a different response from the patient depending on their spoken language. Also, while both full-time and part-time paramedics spoke of the importance of a good partner, part-time paramedics emphasized how it consistently makes a difference to them, since they have a new partner every shift.

Additionally, several paramedics pointed out that a partner’s gender could sometimes be an important factor in managing calls. Some medics noted that where possible it was sometimes helpful to have the female or male medic take the call, and they found people responded differently depending on the partner.

A lot of the time with mental health calls, I find the team dynamic of a paramedic is even more important. Sometimes, a patient just doesn’t like you because they don’t

like you or they don't want to speak to you because of maybe your gender...so, it's great to have a team dynamic and then if one person isn't working you can still kind of... that person can fade in the background and the other partner can be sort of the driving force behind that call.

(Front-line: Interview 025, 2018)

Having the ability to switch between partners attending the call was a benefit, both on scene and during transportation of the patient to the hospital.

Sometimes patients are better with maybe your partner versus you. So we do that as well. Typically, we drive every other call. So, say it's my turn to go in the back {of the ambulance}, and maybe I'm not meshing with the person, but my partner is, we will switch then and then they will go in the back if they have a better bond with them. Sometimes that happens too. Sometimes females don't want males in the back, so if you have a mixed team, that...like the female will go in or vice versa, sometimes if it's, you know, an aggravated male that um...isn't wantin' a female, you know...it depends, it's just, you just have to go with the flow on the call, right, and just kind of get a read on them, and just, do your best if you, you know, if you have a guy-girl team it's, it's always good, but a lot of it, we have lots of females that are permanent partners and... you just kind of hope that they mesh with one of us...That's all you can do really.

(Front-line paramedic: Interview 018, 2018)

Both female and male paramedics spoke of having an aptitude for mental health related calls and both female and male paramedics spoke of feeling like they did not particularly like those calls or did not feel they were particularly patient with those calls. There was no distinct finding with regard to gender dynamics in call management, aside from circumstances in which they felt it was sometimes helpful to defer to the male or female medic. Further discussion on the gendered nature of work is in the Chapter 8 discussion of the origins of paramedic training.

6.2.3 Working with allied resources – Police services

When attending mental health calls, other resources may be sent along with paramedics, depending on the call details and also depending on the particular paramedic service. Certain paramedic services and regions have particular programs in place that result in additional resources such as nurses or social workers attending a scene (see Chapter 9 – Specific

Programming or Projects); however, these services and resources are uncommon and not consistent across Ontario. Paramedics identified that both police and fire department personnel may arrive on the call scene depending on the specifics of the call details received by dispatch, with police having more relevance for mental health because of their role in ensuring safety on scene and in potentially applying the *Mental Health Act* (1990) in determining if they may be apprehending an individual on scene. While differences exist from region to region with regard to available resources, police services are the main one. Police services attending mental health calls may be regional, city police services, Ontario Provincial Police (OPP), or Royal Canadian Mounted Police (RCMP) depending on the location.

Paramedics from many services across Ontario indicated that police are automatically sent with them on several call types including calls that are ‘unknown’ or lacking call details, involve violence or a weapon, and where there are threats of harm to others or the care recipient, such as threats or attempts of self-harm or suicide. The consistency with which police respond to these calls varies by region and rurality. Paramedics indicated that police are often tiered, which means they are dispatched and sent to mental health related calls, or additionally they may request police to attend these types of calls.

The role of police on these calls is generally for paramedic safety or the safety of other individuals on scene (including the individual in need), as well as addressing associated legalities. This might include apprehending someone under the *Mental Health Act (MHA)* (1990) when thoughts or actions of harm to self or others (see Chapter 5 for more comprehensive discussion of *MHA* (1990) in relation to mental health calls), or when criminal activities are presented. Paramedics indicated that a police presence on scenes may offer them some comfort and a sense of backup with regard to their own safety because paramedics’ ability to restrain or subdue someone is limited and it is only under specific circumstances that they can do so. Additionally, paramedics do not carry weapons for self-defence.

Many paramedics indicated that police are a valuable resource for managing mental health-related calls:

The other day actually I dealt with a police officer and he was fantastic (*emphasized*). He, he took the call from us and I really did feel like it was a police matter. That guy was great. He was, he was really kind to the man. He was right on his game.

(Front-line paramedic: Interview 006, 2017)

A paramedic working in a small town within a rural county identified that the police are particularly helpful given their familiarity with the people in town and their knowledge of people's situations, illness(es) and needs.

Because the OPP are here all the time, they know everybody by name, and they're so helpful. They can tell you right away when you go up to an address if they're there. Like, "Okay this guy is like this, he's got this, he can be violent, he's..." and then you're like, "Okay, great." So, they're a great resource... There's really no... you have no idea half the time what you're walking into because you can't keep a record of... where the OPP deal with them all the time so I really like it when they're around. And they're helpful here because it's a small town, so if they see us out a lot of times they'll just stop. So, that's really good.

(Front-line paramedic: Interview 028, 2018)

Paramedics also spoke of police often playing a role in encouraging patients to come with them to the hospital when the patient was otherwise reluctant – something paramedics generally stated was helpful. Paramedics generally spoke positively about the nature of their relationship with police services and often found them to be a valuable part of a team approach to managing calls. While acknowledging their team approach, they also identified how paramedics and police due to the nature of their job have different interests in managing a call, and may not always be focused on the same outcomes. Paramedics may be focused on medical concerns and patient care, whereas police may be focused on a criminal or other legal element of the situation.

I find for us, personally, I find allied resources are very interactive and very cooperative together. There's sometimes a power struggle. "It's like, "Well, hold on, medically we can't do this with them –" Yeah, so for the most part it goes very well for us. We have a very good working relationship with all of our allied resources...

(Front-line paramedic: Interview 023, 2018)

Paramedics acknowledged that as with their own profession there are police officers who excel at managing mental health calls and are well suited to managing these calls, and those who are less so. Paramedics from some regions more consistently spoke positively or negatively about the police interactions in their region. There was often however a variety of opinions on police interaction from paramedics within the same region.

...to be honest with you, some of the police officers here are a million times more, they have more patience than I do. They're lovely. They treat these people with such respect. They wouldn't get this respect in {named another region}. We have nothing to complain about here. They are lovely.

(Front-line paramedic: Interview 026, 2018)

When discussing police as the primary allied resource on scenes, paramedics identified several challenges including, availability of police, police presence exacerbating certain situations, and challenges with liability or responsibility for the patient. Finally, paramedics identified the challenge of having too many people on a scene.

Availability of police was identified as a challenge in both rural and urban settings. In mostly rural settings, paramedics identified that there were often few officers and even if available, it could take them a significant amount of time to get from one part of the region to the other. In one rural area in southern Ontario, paramedics stated that they were down to four or less officers in the region of almost 3500km² to respond to calls through the night. In more northern or remote areas, it is common for the ratio to be even lower. Paramedics stated that when they indicated the highest degree of urgency in their on-scene requests to police, police made it a priority to attend; however, their response remained constrained by their availability and the geography.

Another challenge identified by paramedics with regard to police attending mental health calls is the potential for exacerbating or quickly escalating a situation.

I generally don't like to have police on scene, so I don't know if that helps, if that's a helping aspect because I feel like that uniform tends to...amplify certain patient populations. And it might not even be the uniform, it might be, you know the duty

belt and the vest. Just that persona of like a security guard or like a guard or a soldier or just weapons. That sort of thing.

(Front-line paramedic: Interview 002, 2017)

Along with the general presence of a uniformed police officer, paramedics identified that at times police interact with a more authoritarian style, as this is consistent with their training and much of the other work they do. Paramedics stated this was often not helpful with people in distress or crisis, and could make for more negative interactions.

It's a very fine line when police are involved, because police are almost always dispatched to our mental health calls, just for a safety precaution for us and for them and for the patient and so on. But I find a lot of the police that we encounter want to treat them as a person that, you know, I don't want to say can't help themselves, but they have a very specific set of training and they use it and it's not always the most helpful thing in dealing with a psych patient.

(Front-line paramedic: Interview 031, 2018)

Finally, a frequent comment from paramedics was that it sometimes felt as though the presence of other allied resources resulted in too many people on scene. Even if well intentioned, the presence of too many responders exacerbates the situation, increasing the distress of someone already struggling, especially for someone already hesitant to have sought help because they may feel embarrassed or uncomfortable having that many people involved in their personal circumstances and distress. Paramedics noted that on scenes where paramedics, police and fire departments were all dispatched, the number of people on scene was often particularly overwhelming and counterproductive.

Sometimes I feel like it's pretty unfortunate like in {name of town} we would send almost too many people to help and that is just overwhelming given the situation for some people. They just...they just need one person there. They don't need 12. So I feel like sometimes that can factor in how those calls go.

(Front-line paramedic: Interview 022, 2018)

6.2.4 Managing bystanders – family, friends and the community members

When discussing which people and what services could impact the call scene, paramedics frequently cited bystanders – such as a patient’s family members or friends, staff of community or health service organizations, or people in public. Bystanders were often considered helpful in interacting with individuals with mental health concerns because they were able to assist in calming an individual or encouraging them to go with the paramedics to the hospital to seek further help. In contrast, bystanders occasionally also significantly challenged or exacerbated the situation when paramedics were managing a mental health call.

One paramedic identified that staff in certain mental health or social service facilities made a difference to managing a call:

... when you go to the [community organization] to pick someone up, the staff there is, I think awesome, like a lot of people couldn't do what they do. 'Cause it's not like they're making millions of dollars to do that, like they're doing that because they're good people right?

(Front-line paramedic: Interview 004, 2017)

Another paramedic pointed out that family members could create a particularly dynamic scene, presenting challenges beyond that of working with the patient and also highlighting the importance of working in a partnership.

Some of them {mental health calls} are very dynamic in the sense that you...and what a lot of people forget is on a given situation, you have the patient, but then you also have the family. The family can be very instrumental in helping, or the family can be very instrumental in not helping. (laughs) So you've got to manage the patient, and you've got to manage the family, and there's where a really good partner comes in, cause you can kind of tag-team that, you can separate the patient away from the family, because sometimes you have to do that, and calm things down and you know, sometimes the family is actually more difficult to manage than the patient.

(Front-line paramedic: Interview 020, 2018)

Throughout observation shifts and in some interviews, paramedics spoke of the general challenge they sometimes have with bystanders when attempting to manage a situation. They

refer to members of the public, who while sometimes trying to be helpful in offering information or involving themselves with a scene they have come across, become a whole other element of the call to manage. Bystanders of a variety of types present challenges to paramedics in managing not only the patient but the scene as a whole.

And then bystanders are always a bit of a pain in the butt... 'Cause they're often the cause...not the cause...they're often a reason why they've {the patient} gotten inflamed or...or their situation has gotten worse. You know, they start having a fight...And then they're just gonna keep chirping in the background and I have no way to get rid of that person, I can't force them to leave their own house...so...sometimes bystanders, and of course the alcohol and drugs are always ever present.

(Front-line paramedic: Interview 001, 2017)

The presence of other individuals on the scene of mental health calls was described as a dynamic variable that could both assist with or present challenges for managing the scenes.

6.2.5 Enhancing safety and mitigating violence

Stemming from interviews with front line paramedics, paramedic services management, and to some extent managers in Base Hospitals and educators, two recurring themes were safety and violence. These were described as foremost concerns for managing mental health calls due to what was perceived as the unpredictable behaviours of patients with mental health needs. Many paramedics spoke of safety concerns as their highest priority because of the reality that violence from those in crisis was common. Paramedics spoke of their own and police use of restraining measures, alongside the need for de-escalation in certain situations. Additionally, several paramedics explained how the dominant safety and violence discourse around mental health was a problematic way of thinking and managing mental health needs.

Paramedics emphasized how the majority of their work is unpredictable because notwithstanding whatever call details they have received from dispatch, they often walk into situations to provide care lacking accurate knowledge, history and the context. Along with this, paramedics stated that they are often called in at a point of crisis when people are in distress or when patients' family supports have been exhausted. For instance, they may not know an individual's particular triggers, what may further exacerbate their distress, or whether a person may have intent to harm themselves or anyone else.

And when I say difficult it's because it's unpredictable, and you don't know them, so you're walking in to somebody who has a known mental health issue perhaps, and you don't know what their triggers are, you don't know if they're violent, you don't know if they have something in their bag that they can get at you with. You don't know if they're gonna be good, good, good...suddenly you're in danger

(Front-line paramedic: Interview 001, 2017)

Given this unpredictability, paramedics described their highest priority as how they address their own safety and take precautions to prepare for physical interactions or violence.

And keeping in mind too that when you're dealing with mental health, you don't know how fast they're going to ramp up. If they're going to get violent, if they've got a tendency to get violent. So you've got to think your safety, their safety, your partner's safety, public safety depending on where you are.

(Front-line paramedic: Interview 007, 2017)

Along with this, paramedics spoke of the different skills they have learned and strategies they use to ensure their safety on a scene, such as careful assessment of the situation, keeping space between themselves and the person in distress, using portable radios, and relying on a police presence.

So the most important thing is that we make sure that we're okay, first of all. Because we're always taught in school scene safety. If you're not okay, your patient is definitely not going to be okay and your partner is going to be worse. So we always go in with the assumption that this person is intending to harm us...Like we keep the worst case scenario at the front of our mind and then we work our way backwards. So, typically, you know, it starts off at a distance, trying to work your way, figure out what that person's comfort level is, what's the situation that's going on, trying to do your full assessment and then kind of figure out what the chief complaint is and work from there...With personal safety always being at the front, we have equipment that we can to protect ourselves. Nothing fancy, just like bags and stuff to provide a barrier. But we also have our dispatchers, we can talk with them, we can relay information saying we need other people here, we need a supervisor, we need police, we need whoever. But, ultimately, with these mental

health calls it boils down to your interpersonal relationships and how you speak with these people.

(Front-line paramedic: Interview 030, 2018)

Another skill they relied on was using a direct line of questioning with patients about thoughts of harm towards themselves or anyone else, or if they had a weapon. Paramedics indicated how patients are often very forthcoming when directly asked these questions. As detailed in Chapter 5, direct questioning around harm to self or to others is addressed in the *Basic Life Support Patient Care Standards* (MOHLTC, 2018b).

Several paramedics challenged the frequent assumption that mental health calls and individuals with mental health concerns are dangerous and are presumed to be violent.

Like somebody with anxiety isn't somebody who's dangerous necessarily and you don't wanna...and they're very lumped into the same thing, and you don't want to treat people like they're...you know, like a psychokiller when they're just anxious, they're very, very different... But when we talk mental health, it's the same thing. It's all lumped the same. We need to understand the difference. Like just because somebody...takes Zoloft, doesn't mean that you can't enter their house and they're dangerous, right?

(Front-line paramedic: Interview 006, 2017)

Another paramedic acknowledged that often those being apprehended under the *Mental Health Act* (1990), are not all dangerous or criminals, nor should they be thought of as “crazy,” but some paramedics may assume this. Several paramedics acknowledged however, that mental health calls requiring the restraint of patients or calls that have escalated significantly are in fact relatively infrequent.

And they're not all violent, yet when they have these response teams {including police involvement}, they're all wearing bullet proof vests and you know...what sort of message does that send, right away when you're pulling up in a cruiser and you've two individuals with bullet proof vests walking towards you, just assuming that people are going to be violent when, I think sometimes that escalates issues instead of deescalating them right away and I think we can help a little bit with that...

(Manager in an Ontario Paramedic Service, Interview 034, 2018)

In further understanding where some of the concern for safety originates however, a number of paramedics spoke to their experiences of interacting with individuals on mental health calls when they felt a threat to their safety. Situations across multiple paramedic services included paramedics encountering weapons on the scene and/or perceiving a threat to their safety. A superintendent in one paramedic service stated:

I mean, we've all been assaulted by people who have mental illness. Again, it's not on purpose. They don't purposefully want to hurt {paramedic's name}. That's not what they want to do, that's just the way they react. And sometimes we have to defend ourselves, we receive training on how to defend ourselves and how to prevent to have to defend ourselves, which is also a big part. So all our paramedics receive training in self-defense and verbal Judo on how to, again, de-escalate but I think you can always do more.

(Manager in an Ontario paramedic service, Interview 035, 2018)

One paramedic I interviewed advised me that they are currently working in the office at headquarters on modified duties and not on the road for regular duty as they have been on temporary leave following an incident on a mental health call when they were directly threatened with a weapon. Experiences such as this and others, which involve actual or threatened violence, demonstrate situations of very real concern with potentially serious impacts.

This section described the ways in which paramedics manage mental health calls and provide care. During the on scene management stage of a mental health call, paramedics identified varied perspectives, and use of different skills in the management. Ultimately, communication was identified as a primary means of managing mental health calls, and it was enhanced or challenged with partners, allied resources and bystanders. Paramedics also identified that calls are largely managed with ensuring safety and mitigating violence in mind.

6.3 Conclusion

This chapter provided a descriptive outline of the stages of care for paramedics responding to mental health calls, the ways in which paramedics manage these calls in practice, and the challenges encountered. In observation and in conversation with paramedics, the findings were consistent that there was no protocol or standardized means of managing mental

health-related calls. Despite the variation in call management, I identified five prominent themes in the on scene management of these calls: communication as a tool for call management, teamwork with partners, allied resources, bystanders and addressing safety and violence. Throughout the different stages of the call, other individuals were identified in the role they play for those seeking care in the paramedic services setting, such as dispatch, police, other bystanders, and receiving facility staff in hospital EDs.

From this descriptive chapter of mental health call management and the challenges, the foundation has been laid to further explore the contexts in which care is provided, the tensions between the factors that may either support or limit the way in which care is provided, and the needs of both the paramedic responder and the individual in distress. Next, Chapter 7 will expand further on the conditions for call management and care provision, and will provide analysis and discussion of these descriptions of call management from Chapter 6 and the contexts and conditions of work and care in Chapter 7. The subsequent chapter will address challenges of care in rural contexts, in the ED as receiving facility for individuals in distress, tensions between paramedic and patient safety and the discourse about mental health concerns and violence. Additionally, in Chapter 7 the prior experiences and personal mental health concerns of paramedics will be explored along with the training they receive to manage these calls, and the impact this may have on these calls.

Chapter 7: The Conditions of Work and Care

7.0 Introduction

Paramedic work often takes place in fast-paced, unpredictable settings, in which paramedics must make do when assessing a situation, providing care and potentially transporting an individual to hospital with whatever resources are at their disposal. Paramedics are required to be adaptable and to respond quickly to changing information and circumstances. While this results in rapid and effective action in life-threatening situations, there are also clear limitations to the comprehensiveness of the care they are able to provide, with little information and a short window of time at each encounter. Paramedicine is a juggling act of varied skillsets required on demand, and paramedics are often considered to be a “jack of all trades,” having to blend expertise and innovation with little room for error. While not every call is like a scene from a television show, the conditions of paramedicine work and care are far removed from traditional clinical settings and require continuous anticipation of the unknown. As such, any analysis of the work requires one to be mindful of the inherent conditions with which paramedics must contend.

The previous chapter described paramedics’ practices with regard to managing mental health related calls. It lays the groundwork to present findings about the conditions and challenges for mental health calls – both for paramedics and patients. The working conditions of those providing care cannot be separated from the conditions of those needing, or receiving care (Armstrong & Braedley, 2013). The contexts of prehospital care and transitions from prehospital to hospital care for individuals with mental health needs will be explored. Ultimately the implications of these conditions and contexts on both care work for paramedics and care received by those in distress will be discussed.

This chapter presents a feminist political economy analysis of the conditions of work and care. Feminist political economy draws attention to social relations and the structural conditions in which care work is carried out, and the tensions between these and the agency of care providers (Armstrong, Armstrong & Coburn, 2001). These social relations may include class, gender, racialization, ageism or institutions (ibid). Structures such as paramedic services, community mental health services, hospital emergency department (ED) services, guidelines or policies that direct practice of care providers may impact distress or the need for care. Ultimately, this chapter critically explores these tensions in care provision on mental health

related calls to paramedic services by comparing across case study sub-units, discussing different geographical contexts, and the availability of resources. Further within-case analysis will be highlighted in Chapter 9 when comparing those services with and without mental health specific programming.

Based on observations and interviews, this chapter will present findings about a range of contexts and settings for work and care in sections 7.1 through 7.4: the workload, management styles and morale in paramedic services; the mental health of paramedics; the spaces in which paramedic work and mental health care take place including the community and the ED; and the places of care in urban and rural communities. The example of one mental health transfer call is presented in 7.5 to illuminate the impacts of these various contexts on care and on the individuals providing and receiving care. Finally, in section 7.6 I discuss these conditions and contexts for care. The tensions emerging from these conditions and contexts will be discussed in relation to their impact on care provision.

7.1 Workload, management styles and morale

This section explores the conditions of work as related to workload, the spectrum of management styles and the morale of workers in paramedic services. During observation with a particularly busy paramedic service (Sub-unit 1), where many medics spoke of having little or no ‘down time,’ it was evident that the pressures felt on the day to day, were significant. At the start of the shift, I observed the crew arriving to their station, and preparing for their day:

As they were checking the bags – they said this was a very busy downtown station where they don’t always have the same bags so they had to check these bags (and all its equipment), finding much of it needing replacing and restocking. From my own work, I know this is a stressful feeling at the beginning of shift if you don’t feel your equipment is ready to go and you don’t feel you have what you need to be able to do a call, which could come in at any time. They suggested this might often be the case there.

(Field Notes, 2017)

This observation happened in a service in which there are high call volume demands, and in which paramedics said they received phone calls most days to do overtime, as the service was continually unable to adequately staff their ambulances. Paramedics in this busy, urban service spoke of ‘burnout’ and issues with absenteeism.

...we're a little strained right now... you're never getting breaks, you're not getting off on time...I'm getting called for overtime like every week...They're texting everyone, just...can you come in, we'll take anybody, (laughs) we don't even care about seniority right now, we'll just...we'll take whoever it is. So it's been busy...It's a very busy service and it's always increasing...that's the same everywhere. With those things it's just a little high pressure right now. Typical would be roughly five to seven or eight patients {per day}, which is a lot. Standbys in between. You're not likely to get both of your mandated, half hour breaks...you just don't get them. Some days you'll get one, and some days will be better than others. In general, get in a truck, start doing calls, get stuck on offload delay, and you go back out and "see you in ten minutes," kinda deal and come back in with calls... So there's been a lot of changes lately, so a lot of changes with...equipment, procedures, structure, like organizational structure, things like that, that have been kinda quick, fast, and sometimes hard to handle. But I think it's moving in a positive direction as much as it hurts. And there may be a lot of negatives. I think over all, we're trying to get more positive with... or more professional... about that

(Front-line paramedic: Interview 001, 2017)

Interviews with paramedic services management and front line paramedics as well as observations of paramedicine calls revealed a range of experiences related to the nature and structure of paramedic services. Many paramedics reported advantages and shortcomings related to how their management oversees and supports paramedics. In one paramedic service (Sub-unit 3), a majority of paramedics reported an exceptionally positive experience with their paramedic chief and the way the service is managed and led. Paramedics reported feeling supported and heard, with a chief who consistently made themselves available to hear any insights, concerns or ideas they may have. Positive experiences with management in this service were quite consistent among paramedics. In contrast, in another paramedic service (Sub-unit 2), paramedics reported significant discontent with the management and leadership in their service, indicating substantial disengagement of the leadership from the front-line medics. One paramedic of with approximately 28 years' experience described the changes he has seen to the service structure throughout his career:

We went from...a private service when I first started to a very, very laid back structure, just go with the flow which was really nice and to obviously as over the years, we've

gone into the more... a real government, corporate, top down management where, where I'm gonna say a lot more shit runs downhill. And they...there's not much. The disappointing part, there's no reason for morale to be good, because management certainly doesn't try to build it on any level. They're just kind of, "this is your job, you do your job," and that's fine, I can work with that. Some people can't. But that's just kind of it. So...morale I find a lot of (sighs) I find a lot of...and I maybe went through it a bit too in my thirties. I find a lot of people in their late twenties, thirties, just disgruntled. And I'm not sure even disgruntled, just some are angry, some are disgruntled, some are just not happy,

(Front-line paramedic: Interview 008, 2018)

Another paramedic spoke of her experience working in another paramedic service – one in which I was not observing. She said that they regularly attended 8-10 calls per shift, and in speaking of the paramedics there, said "People there are like the walking dead" (Field Notes, 2018). She spoke at length about the challenges in the service with management style, limited resources, high call volume and ultimately paramedic burnout.

In contrast, to these challenging conditions described, there was a notable difference in a paramedic service I observed in another region (Sub-unit 3):

A member of management met me at my vehicle, saying he had waited out there for me in case I didn't know my way in. I immediately noted that this was above and beyond the organization and preparedness of any other service I have visited.

I was again struck by the extreme 'welcomeness' and genuine friendliness of all of the medics. Before this service every medic I'd met had been pleasant... but there is a distinct difference in the atmosphere here. I tried to consider the factors – they all indicate they're very happy with their management (the chief particularly). Their management took the time to give them a clear heads-up that I would be present for these shifts and they seem to be extremely organized. It seems to generally be a different climate/atmosphere. At various points medics have made comments about changing culture (nitpicking from above) and uptight rules, but overall it seems to be a uniquely positive culture.

(Field Notes, 2018)

Along with my experience of this through my observation, this same commentary was echoed in several interviews, such as this one:

We are very fortunate, and you've got that on record and I will stand by that... we have wonderful management. Our {members of management}, they are fabulous. They will back us up 100%. They're very busy people but when they say open door policy, they mean it. You knock on their door and they will take the time to have you sit down and listen. They will—if you have an issue they will take it to heart... they will try to solve it, but if they can't, they'll tell you. You know, they're not going to suffer fools gladly, as it were, and pretend. I know there are other regions that have a very, very bad uh, issue with management and are very poorly run, and it's kind of a trickle-down effect. If you don't have this, you know, stable, solid management that believes in the workforce, the trickle-down effect is people will not be happy. And that was part of the... problems I found with the {name of another paramedic service} is people are miserable. They don't have the support... you know, they—they don't have the resources they need to do their jobs, and it affects them directly, and therefore the trickle-down effect is sadly sometimes that affects patient care, and particularly, well any call really, whereas {here}, I mean, we've got our problems, don't get me wrong, but by and large, it's a very well run service and people are generally happy.

(Front-line paramedic: Interview 020, 2018)

In contrasting the three paramedic services in which I observed, I found there to be a real spectrum of management styles and contentment with managerial approaches. In one service, paramedics described significant challenges and poor relationships with their management. I heard these concerns consistently presented and it was palpable in the environment. In another service, paramedics spoke extremely positively about their management and satisfaction with this relationship, in a way that was notable in the atmosphere during observation and cited on multiple occasions in interviews. Finally, another service was somewhere in the middle of this spectrum. There was relatively minimal discussion of either positive or negative interactions with management and the management style. There were however frequent and consistent comments about challenging working conditions with high call volume. This offered an informative sampling of the impacts of different management styles and ultimately some aspects of working conditions.

Paramedics also discussed the impact that management in their service has on their mental health. They discussed that 'micromanaging' and 'nitpicking' with supervisors making them feel as though they are in trouble over small issues and is something that wears on them and impacts their chronic stress levels and mental health. Additionally, they spoke of the

positive impacts of management, such as supervisors identifying that they have had a particularly difficult call and offering them some time off the road, or checking in with them.

Conditions in the workplace have implications for paramedic stress, frustrations and ultimately mental health, and similarly, the culture and dialogue around mental health in paramedicine as a whole has implications for both paramedic work satisfaction, mental health and the ways in which paramedics may engage with mental health calls. The conditions related to paramedics' own mental health will be presented in section 7.2.

7.2 Caring for the care providers – mental health of paramedics

While the focus of this research was on mental health calls received by paramedic services, looking at the calls to which paramedics respond, more often than not, when approached about involvement in this research, paramedics and paramedic services initially assumed the research to be about paramedic's own mental health. A majority of participants as well as those encountered through observation spoke at least at some point to the mental health of paramedics. This discussion arose through paramedics' discussion about what guides their practice around managing mental health calls – often personal experiences with mental health, as well as due to the current focus within paramedicine on first responder mental health (described in Chapter 4, Section 4.2.4). The conditions and contexts of paramedics' own mental health has important implications for their own wellbeing as well as the care they provide to those in distress.

7.2.1 Personal mental health guiding practice

When asked about how they manage mental health calls, as noted in the previous chapter, paramedics identified a lack of standards and guidelines directing their practice, but frequently referred to their own experience as a guide in their work. Paramedics spoke of the experience they had based on years on the road and increased familiarity and interaction with individuals with mental health needs, but also of their own personal experience with mental health such as post-traumatic stress. They also spoke about colleagues, close friends and family members with mental health needs. Paramedics indicated that often this personal experience was what guided their practice and way of interacting with mental health related calls more than anything. They indicated that it often increased their ability to interact with individuals in distress, and increased

their understanding of mental health needs and their skills in managing these types of calls. Furthermore, they spoke of the ways in which it helped them to empathize and understand the frustrations of individuals in distress. One paramedic shared that he had personally dealt with mental health concerns and it was this that largely made him care more about mental health calls. Also, his own frustrations in his experience helped him to empathize with his patients.

And I have to preface this, since I'm not being identified, I have dealt with the mental health issue on a personal family level, so I understand some of the frustration, and probably why I'm not one of those typical old medics who just doesn't give a rat's patootie. So I don't want to make it sound like I'm caring just for the sake of being a nice guy (*laughs*)... Been there done that, so...I'm lucky because, what I went through, because of what I do for a living, I accessed help immediately. I walked into the department and talked to three different people, from three different parts of the hospital, who know me as a paramedic, and said I need help now, and I need it like this instant. Not next weekend, not...and I got it and that was professional courtesy. Most people don't have that...

(Front-line paramedic: Interview 003, 2017)

Through interviews as well as when I was present during observations, paramedics opted to share with me significant personal and family mental health needs and the impact this had on their own lives as well as in their work as a paramedic. One paramedic mentioned to me during an observation shift and began to discuss the empathy or lack of empathy for “frequent flyers” encountered by paramedics – a term used to denote repeat callers to the service who often have mental health and psychosocial needs and who call often.

She said: A lot of them {frequent flyers} have had some bad things happen to them and are now alcoholics. I know all too well how quickly things can change and what path you can end up on. Hard to get out of bed in the morning to go to work. Losing a child and having to do this job is tough. She had disclosed to me that she lost her own child in the last several years and eluded several times to some extremely difficult times in her life.

(Field notes 7, 2018)

Paramedics spoke of these personal experiences as really increasing their understanding for how challenging the mental health system is to navigate, despite their line of work and knowledge of the system. Several paramedics also spoke of personal experiences increasing their perspective that the ED is not an ideal place to seek mental health support.

And also one thing I realize after bringing a friend who was having suicide ideation to the hospital ... at one point he was placed into the psych emerg. He went from emergency department into the psych emerg, he said that's the worst place ever. Like, people are screaming, people are all, like, crawling all over the place... I think it's a lot about perception, like ... how do people feel about their mental illness. Like, sometimes unless you live it sometimes it's very hard to understand. I know for me post-traumatic stress was something I didn't know much about until I started to have some very stressful calls and saw people around me suffering from post-traumatic stress. And then you stuck yourself with the survival guilt, why am I okay. I mean, it's okay to be okay but, at the same time, it's really ... you start to see the impact of stress on your colleagues, on your friends.

(Manager in a paramedic service in Ontario, Interview 035, 2018)

While doubtless it is possible there was responder bias in who agreed to participate in interviews, many paramedics I encountered on observation shifts also talked about these experiences. Whether personal, with colleagues, or on the road, mental health presented as a significant factor in how paramedics perceived and managed mental health calls, and additionally provided insights into the challenges paramedics experience in the context of their work, that impact their own mental health.

7.2.2 The conditions of paramedic mental health

As discussed in Chapter 4, awareness of paramedic's own mental health has been increasing and social media, operational, legislation and cultural shifts have been occurring. It was evident through this research, that paramedic mental health has been an important issue within paramedic services, with an increased willingness for discussion and movement. In paramedic services stations where I was observing, there were posters regarding mental health awareness, 'anti-stigma,' and mental health services for those in distress. Additionally, under uniforms, or while in the station, paramedics as well as nurses in the hospitals wore t-shirts or

sweatshirts with #IVEGOTYOURBACK911 written on them, sold as a part of their recent campaign. Furthermore, paramedics seemed keen to discuss issues of paramedic mental health with me. Even when asked specifically about managing patient mental health the conversation often diverted back to discussions of paramedic's own mental health.

'Cause there's just, rampant PTSD here and people don't recognize, or they don't want to admit to it, and, we've learned to look at our neighbours or at our partners to see well how are they doing today? You know, oh they're fine, or, oh no, maybe they might need some talking or...then you go ok no maybe something's really wrong and you have to get a supervisor involved or something, so. We have... sort of have a little education on how to deal with that

(Front-line paramedic: Interview 015, 2018)

Paramedics discussed the transformation that is occurring, from a traditional mentality where mental health is not discussed, and the challenges that have prevented it from being discussed, to one that better acknowledges the realities of mental health challenges for paramedics and is working toward addressing these challenges.

Yeah, and it's different because paramedics they've always been very type-A personalities, and very high strung and not willing to admit that they ... that they're suffering. There's also belief that people don't understand what we're dealing with, they don't understand the scream, they don't understand the visual, so it's hard.

(Manager in an Ontario paramedic service: Interview 035, 2018)

...that culture's changing; I think for the better now. I come from a culture where paramedics, it was frowned upon to speak about how you're feeling after a bad call and, you know, suck it up buttercup and that was the culture that I came from. And it's changing now so that people aren't afraid to step forward and say, hey you know, I'm not doing so well after that.

(Manager in an Ontario paramedic service: Interview 034, 2018)

One paramedic with nearly 30 years' experience discussed the context of mental health needs among paramedics in great detail, highlighting that PTSD was rarely something that just happened and clearly laid out his understanding of the context of mental health, and the circumstances that impact paramedics and individuals' mental health and wellbeing:

I've said to coworkers, I honestly believe that if I took the whole population out there, I believe that probably fifty percent of us have an underlying mental health issue, whether it's an addiction or an instability or depression or what have you. The fact is that the majority of the population, has a house, has some friends or spouse who they can talk to and debrief with, and it's when you add on that extra stress or that all of a sudden you've lost your balance, and maybe that's why in some stressful jobs like paramedic and police and, and you know, prison guard or whatever, well, now when you deal with all the stresses that everybody else does, your bank account, your food, your relationships with your spouse, your boss, and now you add in all of those other stressors, dealing with people who are very needy and challenging and sometimes threatening, well, that sometimes is that tipping point that can cause your PTSDs and, and other mental health issues to percolate at work. You're not coping with them in our line of work as well.

(Front-line paramedic: Interview 005, 2017)

Paramedics discussed current Peer Support groups that have been established to aid in supporting their mental health, as well as having been put through courses such as R2MR (Road to Mental Readiness - established by the military, but increasingly applied to paramedic services), MANERS, ASSIST and other in-service training about paramedics own mental health. Several paramedic services indicated they have recently established dedicated rooms within headquarters stations for paramedics to have a quiet space to sit and talk after difficult calls or other challenging circumstances.

Additionally, paramedics discussed concerns with the practical application of the new legislation (Bill 163: Supporting Ontario's First Responders Act (Posttraumatic Stress Disorder), the type of supports available, and what options exist for paramedics requiring support. One paramedic with 25 years' experience described the challenges they feel still exist for paramedics' mental health:

It's like on one hand they're like, "Oh, we're here for you. We want to give you all this help. We want to give you all this training." But, if you need it you really cannot access it because I was off on a stress leave for six months and it was the worst, most stressful six months of my life because it's not set up that way. You're not set up to... your options are go on light duties. Well, you know what, no. You can't do that...It doesn't help at all because they send you into the office, no you don't want

to be there every day, you can't be there every day, but you can't be off either. Well, you can be off, but you're not going to get paid. I think we still have a very long way to go with mental health in our own job. We got a long way to go.

(Front-line paramedic: Interview 028, 2018)

Finally, paramedics often used humour to discuss mental health needs among paramedics. At the beginning of my observation shifts, medics would often joke about whose mental health I was really assessing. On one shift, after being introduced to a group of medics as a researcher studying mental health calls, as I returned to the crew room, I heard one medic say “Well she won't have to go far, we're all mental health cases here!”

7.2.3 Paramedic's own mental health and implications for patient care

With this substantial focus on paramedics' mental health, what does this mean for their managing of mental health calls? Paramedics discussed the ways that personal experiences positively impacted the ways they understood and interacted with those with mental health challenges, and additionally that the increased discussion and education around paramedic mental health might carry over into their patient care.

I think that definitely opened up a lot of people's eyes to it and that factor of not looking at these people as weak or crazy because you could look internally now and go, whoa, like we all have potentially mental health issues. I know the spectrum can be very wide but I think that definitely opened up people's eyes that it was okay, right, the whole weak, sorry, not sick, not weak, yeah. So probably definitely more aware based on that internal review.

(Front-line paramedic and educator: Interview 037, 2018)

And certainly, like there's a push to recognize within, like the own, our own profession, like mental health struggles with depression, suicide, PTSD. So I think that (*emphasized*) sort of resource that people can tap into to be more mindful of, of clients' needs.

(Front-line paramedic: Interview 011, 2018)

While it seems that the issue of mental health needs among paramedics are far from having been solved, the push to recognize and address needs among paramedics has the potential to connect to the ways in which mental health calls are managed by paramedics.

But the need really is twofold, it's to help each other, but also to recognize in the community how to deal with some of these issues...hopefully by decreasing the stigma within our own peer group we can help to decrease the stigma of mental health to those that we provide service to...so looking after each other will also help them to look after their patients, right?

(Manager in an Ontario paramedic service: Interview 034, 2018)

Having set the stage for the conditions of understanding mental health and conditions in which paramedic mental health care work is occurring, the subsequent section presents findings with regard to the settings of care, exploring the impact of different physical spaces and the conditions that come with them on this type of care work.

7.3 Settings of care

As discussed previously, the working conditions of paramedics and the spaces for care provision for individuals with mental health needs extend beyond the structure of paramedic services themselves, to other spaces of the community and health care system. Chapter 5 outlined institutional care, how historically the predominant space for mental health care provision, was shifted into community spaces. Additionally, Chapter 5 addressed the shift from preventative or chronic care to more acute care needs. This shift has resulted in changes to the primary locations of care from being psychiatric hospitals and institutions, to other community and emergency settings, settings which might have been less frequent locations for care in the past. This section presents the findings about settings of care provision and the transition from home or community settings to the ED as a frequent site of care.

7.3.1 Care in homes and communities

Paramedics discussed the conditions of mental health care in home and community settings in relation to paramedic services, as well as more generally the challenges and experiences they

saw for the patients they attended to. They remarked on the shift to people's homes for their receipt of mental health supports and care, rather than institutional settings.

You know, people laugh at me when I say this, but years ago they had centres...you know, facilities. People always laugh at me because they're like "You can't lock these people up." But they had facilities that these people could go to. Because there are some people in society that just can't function well...that need sort of a structured environment to help them. All these centres got closed and these people got put out on the streets. I almost feel like that was a disservice, because I think some people, not everybody, but I think some people need sort of that structured living environment... But there's no alternative for them. And I feel like when all these centres closed down, that's when our mental health calls just exploded. Because these people went from having sort of the resources that they needed to not knowing how to navigate outpatient type resources...And the connection to the structured environments that some people need.

(Front-line paramedic: Interview 029, 2018)

Paramedics importantly discussed the challenges with not having a 'home' for many individuals. One paramedic noted that while in theory many people might want to receive care in their home, there are inherent challenges with what 'home' looks like for some people, and for others, limitations on what support and care can in fact be received at home:

It's either...a homeless person who doesn't have the support network or...not necessarily even homeless but somebody really, really on the lower end of the... economic scale. They've reached a point where a) they don't have a support network or whatever they do have in place isn't working for them so they've called. And on the other end, is if you've had someone with mental health...issues that is in a good support network situation...they come from an affluent family for instance, when the ambulance gets called, it's now reached a crisis level where, the family and the support network that is available to them, aren't able to cope with, with the emergency that is going on. So, we usually see people in those extremes.

(Front-line paramedic: Interview 005, 2017)

Another paramedic discussed in further detail some of the housing conditions in which 'home' is not necessarily the place for an individual's mental health and wellbeing to be best supported.

I would say you know, like your typical unkempt house, they don't have food in the refrigerator, they're not – Like you go into houses where they're like – I don't mean untidy, I mean like true hoarder type, like you can't move for the garbage or for the stuff or whatever it is, would definitely contribute to that. I'd say places where people live alone or people live with a caregiver situation where it's just the patient and one caregiver are probably more likely to call and just be like “I have no support. I have no help.” Or people that aren't in tune with – they haven't called for CCAC to come help or to get the homecare in that they need. Like those would definitely be factors that I'd say could cause us to be called.

(Front-line paramedic: Interview 031, 2018)

The conditions of people's homes and the support that must come from alternative sources (other than the formal mental health system) were highlighted. Factors beyond the mental health system that create challenges for individuals receiving care in home and in the community were also talked about.

And you know, part of it too is the caregivers not being able to support their loved ones in the home, whereas maybe traditionally that was a possibility. It's not so much now anymore, with some of the, I would say, financial constraints that people have, so that they both like, you see both people working full time jobs just to make ends meet. And then if one had to give up that job to look after their loved one; that would place significant burden on that family dynamic, right. So, they're struggling, I don't think some of this is that they don't want to, it's just they don't know how to or they can't.

(Manager in a paramedic service in Ontario: Interview 034, 2018)

Paramedics identified inherent challenges with care received in community settings. Further, beyond care received in community settings, encounters with individuals in their home and in the community demonstrated the result of transitions in care to other services when paramedics transported individuals from the scene of a call.

7.3.2 The Emergency Department (ED) as a space for care provision

For patients being transported by ambulance from community settings, the hospital ED is the receiving facility and the next step in receiving care. This is also the case for individuals with mental health needs being transported by ambulance. There is some variation in this

transition in the form of alternate destinations for paramedic services, however these are the minority of cases, further explored in Chapter 9. This section presents the ED as a space for the transition in care from paramedics to the next point of care. The ED is related to challenges for paramedics providing care, as well as a place that paramedics observe to be challenging for patients that they transport to the ED.

The ED, as the option for continuing care from paramedic services, was a prominent topic based on my observations, interviews with front-line paramedics, as well as through interviews with paramedic services management, Base Hospital managers and physicians. In Chapter 6 I presented some of the conditions of the ED that paramedics identified to be particularly problematic including, the ED as a setting in which patients are required to wait including: long wait times; waiting in hallways without privacy; and a lack of adequate support beyond a security guard. This sub-section highlights the ways paramedics described the ED as a problematic space for care provision for those with mental health needs.

During interviews and observations, paramedics talked about how they felt the ED is often not the right destination for individuals with mental health needs. They consistently stated that it was not the ideal place to transport individuals from mental health-related calls, and that the ED is not ultimately set up for the type of supports people require. Paramedics acknowledged that certain calls involving overdoses, physical injury or trauma or unknown medically-related complaints may truly require an ED. They identified many calls where people are experiencing distress however, the required support and help for this is not best suited to the ED. As this quote shows, the ED, designed to be a place for medical and trauma care, is generally not designed for mental health care, and those with mental health needs are often seen as inappropriately taking up time and space in the ED.

You know, we're talking about people that necessarily, you know, they need to speak to somebody, but they don't need to see an emergency physician. So, medically, medically, as in there's not, you know they're not having chest pain, and they're not short of breath, they haven't taken anything to harm themselves, but they need somebody to talk to. You know, whether or not, you know, maybe they are hearing some voices, or you know, they've got some panic that they think somebody's following them, or, or something in that regards. Or the people that just feel, you know, they're just feeling down. Could be, you know, Christmas is coming up kind of thing. That ups the game there too. You know, these people that don't

need medical clearance, they just need to speak to somebody. So, in, in having an alternate route for them, is going to be the best thing, then you know, blocking up the emerg department, for a doc that they don't really need to see 'cause there's nothing medically, medically wrong.

(Front-line paramedic: Interview 007, 2017)

Paramedics described that having seen these individuals at their acute point of crisis gives them a unique view on their situation, one that may not always be perceived in the same way once the patients reach the receiving hospital.

Yeah, no I think we have a unique sort of perspective... I mean you can take these people to hospital, you can try to describe it to the best of your ability to the doctors and nurses, but I don't think that they really quite get it, because they don't see it firsthand. They see the patient after you've been talking with them for half an hour after you've calmed them down, after you've brought them in. They don't sort of see maybe the actual crisis in the actual environment. So I think we have a unique sort of perspective there in that we actually do see that. You know, we actually do spend time with these people in the home for, you know, maybe half an hour before we try to initiate transport or whatever. So it's...we're with them for a short window of time, but I think we see a little bit bigger picture. So, yeah, if there were certain resources out in the community that we knew about, we could maybe steer the people in that direction...I feel like the hospital emerg, I don't know if it's that they're dealing with the mental health calls so often that they're becoming very desensitized to them and they're just sort of . . . I don't want to say necessarily not taking them seriously, but they're just sort of kicking them back out quickly and these people are not getting the help that they want, they clearly want and clearly need.

(Front-line paramedic: Interview 029, 2018)

Paramedics discussed that ED staff are often overwhelmed with other medical or trauma emergencies in a setting where mental health needs do not present as the most urgent situation. Additionally, paramedics acknowledge frustrations for both themselves and receiving facility staff in seeing these individuals frequently, with few treatment or support options available in the ED. One paramedic described feeling helpless in their obligation to transport to the ED, where the paramedic does not feel the appropriate care will be received:

You know that at that point the nurses are run down, they're not happy. They don't want to see people, they don't want to talk to people with mental health issues. So you know that that patient's going to sit there for hours and hours and hours because there's no beds available for them at this point. I've seen so many people just walk out because they don't want to wait any longer, and a lot of people know, like, "Oh is it gonna be a long wait?" And as soon as they get there and hear the wait time they leave and at a certain point I'm sure they're, they're going to stop coming back. They're going to stop even trying right? Like they need sort of more TLC than the hospital is able to give them right now. So it would definitely be nice if there were somewhere they could be admitted or if there was, if you could just take them to somewhere they could talk to, like a psychiatrist and they just need to sit down and talk for an hour maybe, right? So I think a lot of the times with the mental health I feel sort of helpless taking them to the hospital, 'cause you know that, there they're not going to receive the care that they're looking for, that they need.

(Front-line paramedic: Interview 004, 2017)

Several paramedics spoke of the exchange of information between paramedic and ED staff being particularly important for the way the patient is perceived. Paramedics commented on frustrations sometimes being shared by both paramedics and ED staff and this translating to the care received. One paramedic with 9 years' experience described a recent call in which she felt the ED was not an ideal place for an individual in distress:

There are sick people in emerg and I think that always becomes the priority and I think mental health patients have this stigma of – I know that's a word that gets thrown around a lot, but they're taking up space and they're taking up resources and "I need that bed" and "You can wait in the waiting room." Like ... we brought a patient in that just could not cope anymore with what she was doing at home. Like she was so shaky and so visually upset and paranoid, so paranoid. She kept asking for reassurance, you know, "Am I going to be safe? Am I safe now? Can you make me safe?" and things like that. This person was clearly in need of pretty significant help. She was not functioning the way she needed to be. And we show up with her and it was a busy day in emerg, like not to take anything away from what was going on, but she got stuck in the waiting. She was there for hours and hours. Like we saw her four, five hours later. She's sitting there by herself, with nobody around, nobody looking out for her. That's a failure in the system, for sure, that this person who

came here for help is stuck in a waiting room, waiting her turn. The damage that that must do, sitting there being so at your limit and just feeling like “I came to this place for help and now I'm being put in the back corner.” Like I can't imagine how that must have felt for that person. You tell a person they're going to be safe and they're going to be better and somebody's going to help them and you need to come to the hospital for help and then they don't receive it in an emergency department. That sucks for them. It makes them not want to come back next time, right?

(Front-line paramedic: Interview 031, 2018)

One senior member of management in a paramedic service stressed the ED's role of “treating and streeting,” something that is not necessarily constructive in managing mental health needs, particularly for those with chronic mental health needs.

I think the role of the emergency department is to treat and street. So, a lot of these individuals, I mean they don't have context either in the ED and they're not equipped to handle some of the reasons that people are there, but there is no other alternative. And so, ED docs, as great as they are, they're not mental health experts and sometimes the hospitals are, loath to, I don't know, ask for further assessments. And sometimes the better alternative is just to let them go and have them follow up with somebody else. There might be still stigmas attached there, I don't know, but they don't get what they need, I feel, in ED. But having said that, there are programs available that these people need, but maybe not, maybe not through the ED, but maybe in another part of the hospital that don't put them in the greater population of people waiting to see a doctor.

(Manager in an Ontario paramedic service: Interview 034, 2018)

This paramedic highlights that negative experiences when seeking support have the potential to discourage the individual from seeking support the next time. By the same token, paramedics also stressed that many individuals with mental health needs who appeared to receive inadequate support in the ED returned repeatedly, making the ED something of a ‘revolving door’ for individuals with mental health concerns.

Like you deal with them for 15-20minutes, you take them to the hospital. They may or may not get a bed at the hospital because they're so jammed up with people in mental crisis. I mean I've dropped off patients there that have waited twenty-eight hours to see somebody, and most of the time, they just walk out of the door right?

And you're like, alright, I'm either gonna pick that person up again later or it's gonna be the same thing.

(Front-line paramedic: Interview 002, 2017)

Paramedics discussed the spaces of home, community and the ED for mental health care provision as spaces with a number of challenging conditions, and as spaces which are largely not designed to meet the needs of individuals with mental health needs. The subsequent section explores work, care and place, and the broader rural and urban conditions in which work and care take place.

7.4 Urban and rural care settings

While the realities and conditions of work in paramedic services, community settings and EDs have similarities throughout the province, differences exist between conditions in rural and urban communities. Through my observations as well as interviews, differences emerged related to the experiences of mental health needs and mental health care in urban versus rural communities. Paramedic services in both urban and rural settings presented with needs for mental health and psychosocial related calls, but each with different circumstances, factors potentially driving calls to paramedic services, and different options for care. This section presents the conditions for work and care in urban and rural paramedic services.

7.4.1 Urban communities

In their discussion of mental health and psychosocial care work in urban communities, paramedics spoke mostly of the high density and volume of mental health and psychosocially related calls. They described a large population of homeless individuals with mental health needs that they encountered frequently, as well as the draw to the city of local mental health and social services agencies. They indicated a higher proportion of individuals with inadequate or no housing with food and shelter needs often unmet.

A larger proportion of individuals with significant mental health needs and precarious living conditions potentially contributing to distress were evident during my observation and even when meeting participants for interviews at a downtown library location from the primarily urban paramedic service. After one interview the participant noted how many individuals with mental health needs to whom they were often called were present in and around the public

library downtown. They jokingly asked if this was why I had selected that location for interviews. Paramedics in interviews and observations alike generally referred to a high volume of mental health and substance use related calls in the city. They referred both to the benefit of more plentiful and accessible social services and mental health agencies in the city, but also to an often high volume of calls arising from in and around these services and agencies.

Paramedics additionally discussed that they felt that much of the increase to mental health related call volume in the city came from the closing of mental health institutions both in the city and in surrounding towns and cities (Section 5.3.2). While there are a greater number of centrally available mental health supports and services in urban areas, it seemed that many of these services were overrun, with mental health and psychosocial needs still unmet, and paramedic services frequently encountering calls as a result.

Consistent with their description of a high mental health related call volume for paramedic services, paramedics reported how mental health was a substantial portion of paramedic workload in urban areas. Several paramedics, such as the one here, described that the high mental health call volume was in fact a significant frustration and reason to avoid working in downtown areas:

...one of the reasons I left downtown is because all of the patients downtown at times were just mental health patients. And that drags on the medics.

(Front-line paramedic: Interview 003, 2017)

They indicated that the density of calls in city centres sometimes meant that ambulances from the surrounding counties and more suburban and rural areas were pulled into the downtown core, something that they generally did not want to do.

I mean, most people prefer to be in their area and most people would prefer not to be downtown, like ever (laughter). But um, yeah, at least three times a day we're doing standbys somewhere else.

(Front-line paramedic: Interview 001, 2017)

At the same, time, other paramedics spoke with a certain amount of pride in their ability to work downtown with this population, that they liked it and for the most part these were “easy calls,” usually indicating this because patients would walk to their stretcher or ambulance, and did not

require significant intervention. Additionally, transportation times were relatively short for paramedics transporting individuals to the ED from within the city, including to local mental health hospitals when possible. Ultimately, paramedics spoke with an awareness of the conditions specific to paramedic work and mental health needs in urban communities and an awareness that these conditions were significantly different to more peripheral suburban or rural communities.

7.4.2 Rural communities

This section describes paramedics' experiences with care provision in rural settings for mental health related calls. They discussed the context of mental health needs for individuals in rural communities including experiences of geographical and social isolation and limited community services or community mental health supports. The context involved paramedics providing care across a large geographical area with few surrounding resources, and limited hospitals or other receiving facilities that managed individuals with mental health needs. These distances and lack of resources resulted in frequent transfers by ambulance to hospitals out of region.

Paramedics working in rural communities identified several potentially challenging determinants leading to distress in rural communities. Geographic and social isolation along with limited community services and community mental health services for people requiring support were identified as primary determinants contributing to people's distress.

As noted in chapter 4, social and geographical isolation were identified as potential causes of distress, something paramedics saw when attending to calls in rural communities. In some cases, however, paramedics identified that isolation might be experienced differently in rural compared with urban settings, or that people were sometimes well supported in rural communities. One paramedic who previously worked in a far northern, remote community but when interviewed worked in an urban community within southern Ontario stated how they saw isolation and loneliness in both settings in different ways:

In specifics, there's some regional differences. When I worked up in the far north {name of community}, depression led to a great deal of substance abuse, and suicide. But I don't remember seeing so many people having bipolar and schizophrenia and, and other disorders that way. Now, in an area where there's more, general services like, you can go to a grocery store and

it doesn't cost you ten bucks for a thing of milk. In those situations, there wasn't as much, although depression was kind of still out there. There's a different flavor, you might see, in the city here there seems to be more psychoses and, and things like that going on. Um, in smaller communities, because you, when you have a population of only 2000 people in a small town, when everybody knows that person, whose having mental health issues, whether they know it or not, they become a support for that person as well. Whether it's that we all know that, made up name, Tim has some bipolar issues. Well... my choices are, I can still, you know, wave to Tim and say, "Hi Tim, how are you today?" and interact with them. I might not want to get necessarily involved with trying to support them through their day to day, but even that small interaction with everybody knowing everybody would probably be a support for that person. Whereas when you're in a big city and few people know their neighbour, even though you're surrounded by more people, you can be more isolated. So, there's regional variations that way. Even though, in, once again, in the city, you might be closer to a number of different...whether there's doctor, psychologists have their office in town, so it might be easier to get to those support services, in between getting to there you might feel more isolated.

(Front-line paramedic: Interview 005, 2017)

One paramedic who worked out of a small rural town stated that she found that the nature of their small town meant that they received fewer calls regarding mental health challenges.

This is just a town where people... like elderly neighbours... neighbours take care of elderly neighbours here. I noticed that. Here when you go, there's always a neighbour or somebody across the street has come over to check. The town is pretty attentive that way. It's a good little town.

(Front-line paramedic: Interview 028, 2018)

By the same token, paramedics referred to significant isolation for people in rural communities, particularly with severe weather limiting travel or for those without a vehicle. They also referred to the conditions of both living and working in rural communities where people sometimes have little work available to them in the community, as well as people having little to do to pass the time.

You know, people will be living in, around here we find people living in old farm houses out in the country without a car, without a way to go get groceries, you know, would you feel happy about yourself in those circumstances, right? So it's all just a big, it's all just kind of a big circle, 'cause

they've ended up in those circumstances because they're not able to hold down a job because of mental illness and, and how are you gonna feel better and get out of that cycle?

(Front-line paramedic: Interview 010, 2018)

Most paramedics identified insufficient or inaccessible community mental health supports and services as a challenge for rural communities. They identified that often people had to travel long distances to cities to access services, something that might not be feasible depending on available transportation and cost. For those services that do exist in communities, paramedics stated that there are often substantial wait times, a problem for those requiring ongoing support and trying to prevent escalating to the point of crisis. Several paramedics in a rural region specifically identified severely limited or non-existent services for youth mental health, as well as addictions services and rehabilitation.

...there's no, there's nothing for anybody under 18 in the area ...For... addiction crisis, addiction counselling, beyond, you call somebody, there's no immediate... area for them to go to right?

(Front-line paramedic: Interview 008, 2018)

I know that they're trying to raise money...I saw it on the news or whatever, they're trying to make like, raise enough money to get like a treatment centre in the area for teens 'cause there is nothing ...Like for teens. I don't exactly know what all they're doing, but it's mainly for drug abuse and anything to deal with...teens and the problems that have happened in that circle

(Front-line paramedic: Interview 012, 2018)

While there may be fewer calls and a smaller population, there are typically fewer ambulances to respond over a large area. Furthermore, weather conditions are often more severe, making travel and transport across significant distance in rural areas even more challenging.

Paramedics also identified benefits to working in rural communities.

The joy of rural is when people call they usually need us. This division, this centre area will sometimes get some of those BS ones, but the outlying never really get them. It's always you're actually needed and it takes a lot for them to call you. So you'd better give them proper care, because they're not going to want to come back and call you if –

you know. So it's getting better, it's getting busier, people getting more accustomed to the fact that the service is available to them. Again, younger era coming up, they know what's available and they're not so much of the hardcore "I can take care of myself" attitude.

(Front-line paramedic: Interview 023, 2018)

This paramedic identified the benefits of rural paramedicine meaning more "real" calls, and also identified the benefit of a generally lower call volume and more downtime in rural paramedic services.

Unlike a busier service, the joy of a rural service is that you tend to have a little bit more downtime. Whether that's positive or negative, it's depends on your version or your vantage point, I suppose. Come in, sometimes we'll do transfers into the city for, you know, staff transfers or we'll get some mental health calls or we'll get some drunk calls or, you know, typical of every service, we'll get that variety of calls. But a lot of downtime, a lot of driving often, so interactions with your partner on a regular basis. Close confined quarters as per usual, but sometimes you have more time just alone with them kind of thing.

(Front-line paramedic: Interview 023, 2018)

7.4.3 Inter-facility transfers between rural and urban areas: Traveling for mental health care

Paramedics in rural services spoke of limited mental health resources and EDs that will do little or no mental health patient care, with the result often in transfers from small, local hospitals, out to either other hospitals in the region with mental health units, or directly out of region to urban centres with mental health services.

We do a lot of inter-facility transfers as well. In regards to the whole psychiatric side of it is we don't have a psychiatric facility within the county, so most of our psych patients that we deal with, even if we don't bring them in specifically, are transferred from {small town names} to {name of small city}, which is something that we would be responsible for.

(Front-line paramedic: Interview 031, 2018)

Well because we know they're going to be transported out anyway, to {name of town} or to another facility for mental health, because they don't stay at those hospitals. Because, so... {name of larger town} is really the only one that will keep them. 'Cause,

as you saw today, our emergency department at {name of small town hospital} has 4 beds, so they can't stay in the emergency department there anyways. So like you said, it's killing two birds with one stone by just taking them to the facility that's going to best benefit them. And then if there are no beds there, they can be transferred elsewhere but at least they're getting that psychiatric mental health assessment and all the beginning process I guess, so to say for it. And then, it can be dealt with at a different facility that's the same equipment if not better. Whereas like here, it's the same as deliveries. There's one hospital in the entire county that does births. If you were to bring them to the....one, if you were to bring them to {name of small town} instead of {name of larger town}, you might as well just bring them to {name of larger town} 'cause they're gonna be sending them there anyway.

(Front-line paramedic: Interview 017, 2018)

Paramedics in all rural regions spoke extensively about inter-facility transfers within or outside of their region. They often made reference to these transfers as a delay in mental health care with longer waits for individuals in distress or with mental health needs. They spoke of individuals receiving little or no mental health support at the local hospital, as the hospital is not staffed or equipped to do so, and substantially longer waits as they awaited transfer out to a hospital able to accept a mental health patient. They referred to this as being problematic for patients in terms of the quality and timeliness of care, and frustrating for paramedics who must transfer the patient to another facility.

Urban and rural settings and the transitions in between are another part of the context impacting the conditions of work for paramedics and care provided by paramedics. Paramedics pointed out positive aspects such as accessible services in urban centres and smaller, potentially more supportive communities in rural areas, as well as negative aspects, such as overwhelmed mental health and social services in urban centres and inaccessible services in rural centres. The setting context created unique conditions for individuals with mental health needs as well as the paramedics providing mental health and psychosocial care.

7.5 The example of Jill²: A rural mental health transfer

Jill is a young woman I encountered during observation in a rural paramedic service. Her story highlights the contexts of care received in a rural ED with limited resources and the

² Pseudonym.

transition to a larger town hospital to receive care. She required a transfer by paramedics to another hospital for further mental health care. Additionally, Jill's story highlights the ways in which safety and danger may operate in a rural ED setting. This particular transfer and the situation surrounding it highlight the challenges that exist for paramedics and ED staff caring for an individual with a mental health issue, as well as the experience of Jill receiving care. I observed this call with two front line paramedics, a member of paramedic services management and ED staff including a physician and nurses.

This call was received by the responding paramedic crew as a mental health patient transfer from a small local hospital ED to the regional, but still rural hospital with a psychiatric ward. I arrived at the hospital with the supervisor with whom I was observing. He had not specifically been requested to the call but was attending due to my observations. On our arrival, the transferring paramedics had already arrived. Nursing staff met the paramedics and provided some updates while the patient and other ED staff were in a room adjacent to the nursing station. The nurse updated paramedics by telling them that the patient was over 300 pounds, was well-known to nursing staff with a history at that hospital and she was being transferred out to the regional "psych ward." The nurse advised that the patient had been at her family doctor's office and before the doctor was in the room, she drank a small amount of a non-consumable substance found in the exam room. She stated that the voices told her to do it. She told her family doctor that she had done this, and the patient was brought to the ED.

The nurse stated the patient has been extremely aggressive, it took 10 staff to manage her, and that in the past she has injured nursing staff and had them off on injury. She has a history of ADHD {Attention Deficit Hyperactivity Disorder}, OCD {Obsessive Compulsive Disorder}, bipolar and a history of trauma and takes extensive psych meds. Patient is currently in 4-point restraints on a stretcher and has already even been given Ativan, Haldol, midazolam "enough to take down a horse" as per staff and she is still able to stand. One paramedic went in to speak to her, very calmly and explain that she is being transferred to another hospital. Patient was saying "I have to pee." Nursing staff state, no, she will have to wait, she is "not to be trusted." The one medic hesitated but the other medic pointed out that we did not see what they {the hospital staff} had to deal with. The transfer was scheduled for them to have an RN {registered nurse} transfer with them. The one medic pointed out that the patient had been quite calm with her until the RN got in the patient's face, then she became more agitated.

(Field Notes, 2018)

Hospital staff and paramedics discussed possible means of having the patient moved from the hospital bed to the paramedics' stretcher and took some time to prepare for this.

It took 5 hospital staff and 3 paramedics to move the patient over from the hospital bed to the stretcher and get her back into four point restraints on the stretcher as the patient continued to slip out. The patient appeared to have a lot of size and power behind her and as per the medics, she did. During the process the RN administered more medication and took additional Haldol and Midazolam for the transfer. The patient said "stop giving me medication." She was not loud and aggressive, she was just pushing and slipping her hands away, stating "I just want to go home."

It took approximately 30-40 minutes for the patient to be loaded into the back of the ambulance and fully restrained. More Ativan was administered while trying to load her in the back – she kept slipping her hands out of the restraints. She continued to struggle while being loaded into the back. Throughout the process she kept trying to rock the stretcher – with her size, it would be very possible for her to rock the stretcher and for it to fall over with her still attached. Staff were attempting to prevent her from rocking.

(Field Notes, 2018)

During the transfer, I did not ride in the back of the ambulance with the crew but instead rode alongside a supervisor to whom I was assigned for the day. We planned to meet the crew and patient at the receiving hospital, in part so I could see the hospital as part of my observation, but also so there would be additional hands available from the superintendent. As the crew departed the scene of the local hospital, they requested that police rendezvous with them and follow them to the hospital, and requested an additional crew to assist upon arrival at the destination and to move the patient from ambulance to the psychiatric ward.

When we met the patient at the hospital, the additional crew was present as well as the Ontario Provincial Police for the region. When we met the paramedic crew that did the transfer, the paramedic that was in the back of the ambulance with the patient was sweating and red in the face. The paramedic stated that the patient had been calm most of the way but then started to fight again.

We all went upstairs, two medic crews, myself, RN, 2 OPP with the patient and several psych ward receiving staff were there waiting. There was a room with two beds and a four-point restraint belt laid out on the bed and a diaper on top of that. They began to get {the patient} undressed with everyone still in the room. Most of us turned around but the ... staff seemed to have very little regard for that.

(Field Notes, 2018)

The case of Jill presents examples of a number of the contexts and conditions for paramedic mental health work and care through care in the ED, in a rural setting. Despite the many health care providers present in this situation, it took significant time, energy, physical and chemical restraint to carry out this transfer. Importantly, none of the care providers at the sending hospital, were mental health workers of any kind, but rather ED, acute care staff and paramedics. Physical and chemical restraints are not necessarily uncommon for patients with mental health needs in the prehospital and ED setting, however this presented as a particularly challenging situation in which neither seemed to be helping significantly. Staff had substantial difficulty getting the physical restraints on the patient, keeping them on, and once in place, the patient then attempted to rock the stretcher and tip it over. Also, as the staff noted, the chemical sedation did not seem to be calming the patient or lessening the struggle between them.

In this situation, there is a tension between concern for Jill who has expressed she does not want to be there, does not want to receive more medication and who is in need of support and care; and the health care providers who report that they have already had significant physical struggles with the patient and are aware that she has caused significant physical injury to other health care providers in the past. Acknowledging the concerns for all involved, it seemed that perhaps there could be another way. The conditions in Jill's case as well as the other conditions outlined above will be discussed in the subsequent sections.

7.6 Discussion

In this section, I discuss the conditions of work and care for mental health and psychosocial calls to paramedic services. This discussion arises from the descriptions of care from Chapter 6 as well as the descriptions for care conditions presented above in Chapter 7. First, I discuss the context for paramedics' work, with changes and challenges for workload, management and morale. Second, I discuss paramedics' own mental health and the implications for paramedic

wellbeing and the care they provide. Next, I discuss the theme of violence and safety which emerged significantly as a condition for care providers and recipients. Finally, I discuss the settings of care: what it means to provide and receive care in the home and community, the ED as well as urban and rural locations.

7.6 1 Workload, management and morale: Changes and challenges

Paramedics' work conditions affect their wellbeing and how they can provide care to individuals with mental health and psychosocial needs. Along with the challenges identified by paramedics, the paramedicine literature identifies a range of challenges in paramedic working conditions which provide context to the work they do. Changes to paramedic workload have resulted from union input and demands (Service Canada, 2015) and efforts to enhance system performance of paramedic services such as decreasing response time to calls, driving change in system management (Blackwell & Kaufman, 2002; Lam et al., 2015; Service Canada, 2015). Some changes have made the working conditions more challenging, which is reflected in 'alarmingly high' turnover rates and significant absenteeism (Service Canada, 2015). Challenges in the work environment include the chronic, operational stress of shift work, organizational stressors related to management, adequate resources including staffing (Donnelly, Chonody & Campbell, 2014), issues and debates around professionalization of paramedic work (McCann, Granter, Hyde, & Hassard, 2013), as well as 'turf wars' between paramedics and firefighters (CBC News, 2015; The Star, 2015) in addition to exposure to and involvement with acute, traumatic events. Paramedics discussed varying satisfaction with management and morale in workers as a whole, potentially affected by this range of factors and conditions. These pressures experienced as a part of the daily working conditions for paramedics have implications for paramedics' own mental health and the care they are able to provide.

7.6.2 Paramedics' mental health

Given the significantly increased presence of paramedic mental health on the radar of paramedic services and in policy, and the knowledge that chronic workplace stressors present as a substantial contributor to challenges with paramedic mental health (Donnelly et al., 2014), it is evident that working conditions have implications not only for paramedic wellbeing, but also for the care that they are able to provide. A recent study of public safety personnel in Canada

(municipal/provincial police, Royal Canadian Mounted Police, correctional workers, firefighters, paramedics and call centre operators/dispatchers) identified approximately 49% of paramedics screened positively for mental disorders. This percentage is greater than firefighters, municipal/provincial police and dispatchers and less than correctional workers and RCMP (Stewart & Asmundson, 2017). Paramedics in this study discussed concerns with paramedics' own mental health frequently and also discussed the range of initiatives in place to address paramedic mental health.

While strides are being made in better supporting paramedic mental health, challenges remain. Paramedic mental health is often being addressed but as an individual problem of paramedics versus as human responses to sometimes immensely challenging working conditions and experiences. While there are positive shifts in legislation, mental health has been medicalized such that diagnosis of PTSD by a psychiatrist is required in order to receive workplace WSIB benefits. This leaves other stress and anxiety related concerns unaddressed, uncompensated and potential for overdiagnosis of PTSD in order for paramedics to receive workplace benefits for their mental health concerns.

Despite the limited attention that mental health calls in the paramedic setting have received, it seems that the movement on paramedic mental health has the potential to offer an opening to address patient mental health calls. Timing is often critical for policy change (Stone, 2002) and this window of opportunity in which paramedics' mental health has begun to be addressed offers potential for change in policy, guidelines and practice for paramedics providing care on mental health calls. Paramedics identified that their own mental health is increasingly being considered and valued as demonstrated by the relatively recent additions of Peer Support groups for paramedics, mental health awareness courses for paramedics such as R2MR, MANERS, ASSIST, the establishment of dedicated mental health rooms in paramedic services stations, #IVEGOTYOURBACK911 campaign paraphernalia worn by medics and other health care providers, and the recent changes to first responder mental health legislation. With the climate in which their own mental health is being recognized, increasingly valued and the understanding that stress and distress may significantly impact everyone, there may be an increased openness from paramedics to engage in further training and a generally increased ability to relate this to patient care.

7.6.3 Violence and safety

As discussed in Chapter 6, the themes of safety and violence presented as a significant piece of context on mental health calls. These themes were salient across multiple domains, such as paramedic guiding documents, police presence on scenes, security services at hospitals, paramedic training and dialogue. Both receiving care and providing care with considerations of safety and violence are important contexts for mental health calls and paramedicine as illustrated in the example of Jill.

People with mental health needs being perceived as dangerous has existed historically, (Hewitt, 2008), including portrayals of people with mental health needs in the media as violent, dangerous and unpredictable. These portrayals may have some association with increased beliefs about dangerousness and mental illness (Hewitt, 2008; Reavley, Jorm & Morgan, 2016). Despite this persistent and salient belief, evidence indicates that individuals with mental health concerns are in fact more likely to be the victims not the perpetrators of violence (Reavley et al, 2016). Ultimately though, discourses of dangerousness and mental illness have had significant influence on the focus of contemporary mental health services (Hewitt, 2008).

Mental health policy has become increasingly dominated by a focus on violence prevention and alleviation of public concerns about dangerousness from those with mental health concerns in the community. This increased dominance of violence prevention discourse at the policy level has had implications at the service delivery level with substantial focus on risk assessment and management (Hewitt, 2008). In a meta-analysis of health professionals' attitudes toward dangerousness and patients with comorbid mental and physical health conditions, Giandonoto et al. (2018) found those working in EDs, and other medical and hospital wards reported poor confidence in mental health care skills resulting in increased perceptions of dangerousness, and negative attitudes and stereotypes impacting quality of care for those with comorbid physical and mental health issues.

Dominant discourses of violence and dangerousness have substantial implications at the level of healthcare settings as well as at social policy levels.

Being constructed as dangerous is a powerful mechanism that sets the stage for epistemic violence...Protecting public order, which represents the well-being of many at the risk of abrogating the rights of the individual becomes central to the

justification for the use of such interventions as forced hospitalization, observation, medication and restraint.

(Lieggio, 2013, p. 126-127)

Discourses of dangerous individuals with mental health needs appears in the prehospital setting. As described in Chapter 6, when asked about managing mental health calls, paramedics frequently made reference to being prepared to address safety concerns for themselves or patients, and a potential for patients to be aggressive or violent. As discussed in Chapter 5, the theme of safety and management of aggressive patients was also the primary focus of the formal guidelines and directives around managing mental health calls. In fact, managing safety and violence was essentially the only reference to providing care on mental health calls in both patient care standard documents.

As discussed by paramedics, the standard presence of police on mental health related calls also exists within a context of safety and potential for violence. Other measures for managing safety concerns in the transition from paramedic services care to hospital care included restraint beds, seclusion rooms, and security guards lining the hallways. When discussing the transfer of care of patients to hospitals, paramedics discussed multiple measures in place to address potential violence from patients with mental health needs. The narrative of individuals with mental health concerns as violent or dangerous is problematic when the predominant focus and guidelines in mental health service provision are based in violence prevention, with substantially less focus on mitigating violence, the implications for individuals in distress and the quality of care they receive.

Some paramedics problematized this frequent framing of individuals with mental health needs as dangerous or violent, identifying that this creates a poor quality of care for people who need support, and additionally, that calls that escalate to a point of violent altercation or interaction between patient and paramedic are relatively infrequent. However, paramedics did discuss their experiences of encountering violence on mental health-related calls, and their sense of a need to prepare for violent interactions. Paramedics noted that they are typically called in as a last resort, when a situation has reached a point of crisis and those on scene have reached their capacity to manage the situation. Situations have already escalated by the time paramedics are called.

Recent studies have drawn attention to the experience of violence in the workplace by healthcare professionals (Gillespie, Gates, Miller & Howard, 2012; Magnavita, 2014; McPhaul & Lipscomb, 2004; Speroni et al., 2014). A majority of Canadian paramedics surveyed experience violence in the workplace, most commonly by patients, and with significant consequences to paramedics' mental health and wellbeing (Bigham et al., 2014). Violence is often considered unavoidable in healthcare settings and seen as a part of "caregiver culture" (Geoffrion, 2015; Gifford & Anderson, 2010) yet has negative outcomes which may include burnout, loss of empathy, poor service delivery, absenteeism, employee turnover and mental health diagnoses such as depression, anxiety, psychosomatic disorders (Geoffrion et al., 2015).

In other care work settings such as LTC, the expectation that violence and safety concerns are a regular part of everyday work – or 'normalized violence' have been problematized. Daly et al. (2011) highlight the importance of the context in which violence or aggressive encounters occur, noting for example that poor working conditions (and poor caring conditions) such as short staffing, limited time, and subpar care models exacerbate the likelihood of violent encounters, and furthermore that in settings in which those conditions do not exist, violence does not have to be an everyday experience. Of consideration in the prehospital and emergent hospital mental health care context, are how the lack of available support, the lengthy, unsupported waits in the ED, consistent presence of security and readiness for aggressive encounters, may be relevant factors to consider in what leads to increased agitation and violence. Additionally, the lack of trained mental health workers available in these contexts may be relevant.

Tensions exist in the need to ensure safety for paramedics in their workplace, but also in the need to ensure the safety and appropriate support and care for individuals in crisis and with mental health needs. Furthermore, the conditions that lead to escalation to become violent must be explored, and means of de-escalation and training for de-escalation enacted.

These conditions of work and care, for both paramedics as care providers and the care recipients present insights into the challenges faced for both, and the limitations that may exist for individuals providing and seeking care. The subsequent section will discuss conditions in the context of specific spaces of care.

7.6.4 Settings of Care

As discussed in Chapter 5 mental health care has shifted from more formalized settings such as hospitals and historically psychiatric institutions to care in communities and homes. These shifts present challenges related to affordability, as well as integration of services (Wiktorowicz, 2005). Mental health care received in hospitals and institutions was publicly funded, with care and services based in one institution. As care has become dispersed into different areas and settings in the community, public funding exists for some but not all services. While community mental health services do receive public funding, many counsellors or therapists (and specifically many non-medical and non-medication based options for care) are private and at the cost of the individual, and requiring greater reliance on families and other informal caregivers for support in the community (Milligan & Wiles, 2010). Additionally, while some community mental health services are publicly funded, challenges exist with integration, accessibility and navigation of multiple services (Wiktorowicz, 2005).

As care provided at home is less publicly 'visible', the shift from care in institutional settings to more fragmented, private, often less-visible community-based settings both enables and is shaped by a stealthy informalization and privatization of care as the costs of care are shifted away from collective society to individuals and families.

(Milligan & Wiles, 2010, p.747)

As paramedics identified, this shift from institutional to community care raises questions about the ways in which care is provided, who ultimately is providing that care, and what individuals and families are to do when they are not able to cope or manage on their own? While not suggesting that institutional mental health care as it existed historically was ideal or necessarily appropriate care, it is important to consider the challenges that exist with the movement of responsibility for care into multiple community and private domains. The following sections discuss the challenges in care settings, not only as physical locations of care, but in the contexts that accompany these locations of care.

7.6.4 (a) *Care in the home and community*

The spaces where paramedics provide care matter, and these spaces impact upon the care provided and received. Shifts in the location of care importantly have implications for *who* is responsible for delivering care (Milligan & Power, 2009). Paramedics identified that they often

received calls for mental health or psychosocial needs where individuals or families in the role of care providers, felt they had no other options. They indicate that in fact burnout of the care provider may be the primary reason for the call. Milligan & Wiles (2010) identify that most community health and social care services would be unable to manage without the input of informal care providers, including family and friends who are acting as a primary mental health support.

An additional consideration is that when care is provided at home, this may look very different depending on what 'home' looks like for an individual. Where care in institutions and more formalized settings may be somewhat standardized spaces such as hospitals, clinics or other spaces designed to meet care provision needs, the home is not a universal space (Dyck et al., 2005). Paramedics noted that for many individuals they did not necessarily have a home at all and might reside primarily in shelters or on the streets. While these individuals may then be connected to the publicly funded shelter system or other elements of the social system, these are not necessarily mental health support services, and are not necessarily ideal settings for social and mental health care provision. Additionally, challenges may exist in the degree of coordination and integration between mental health and social services (Wiktorowicz, 2005). While for some receiving care at home is appealing and comfortable, this is not the case for those who are homeless or whose living conditions and other determinants of mental health may in fact be a significant contributor to distress. One potential result of care shifting into homes and community settings is individuals moving to inner-urban areas to seek support. While no longer long-term patients in hospitals, these people may become "revolving door" patients with frequent readmissions to hospital (Milligan, 2005).

Community-based mental health care has in many circumstances proven inadequate (Milligan, 2005) and is based in care policies encouraging individuals to remain at home, relying on informal caregiving supports such as family, friends, and neighbours for day to day support (Milligan & Power, 2009). The challenges faced in these home and community contexts are impacted by what limited choices for other care may be available. As identified by paramedics and paramedic services alike, when gaps in community mental health care are present, emergency services often play a role in filling this gap. While this offers a potentially robust role for paramedics, paramedic services identified that they are largely overwhelmed by their volume of mental health and psychosocial calls, in a system already significantly taxed by medical,

trauma care and increasing chronic health care needs. Furthermore, while paramedics and other emergency services are playing a role in filling this gap, it is not to say that they are the ideal service or setting for mental health support and care provision.

7.6.4. (b) Emergency department care

The ED has been identified as a form of social welfare institution, available to all, at any time, serving as something of a social service agency, particularly after hours (Gordon, 1999). In relation to mental health, the ED may serve as an initial point of contact during a mental health crisis (Marynowski-Traczyk, Moxham, & Broadbent, 2013) and is particularly in demand when community resources are unavailable or limited (Clarke, Dusome, & Hughes, 2007). Addressing mental health needs has become a rapidly increasing area of focus within emergency medical practice (Larkin et al., 2009). Individuals may present to the ED with mental health needs, issues related to substance use, acute or chronic health issues in conjunction with mental health issues, suicidal ideation and suicide attempts (Wise-Harris et al., 2016). Between 1971 and 1984 emergency visits to hospital for all issues increased by 53%, specifically emergency visits to psychiatric hospitals increased by 156% (Wellin, Slesinger, & Hollister, 1987), and further, emergency visits for mental health concerns are still identified as the fastest growing concern in emergency medicine (Larkin et al., 2009).

While the ED is a common location for those requiring mental health services, a number of challenges exist with mental health care in this context. Long wait times when in a state of distress are problematic (Clarke et al., 2007). Service users often identify that they ‘have nowhere else to go,’ but also report negative attitudes of staff (Clarke et al., 2007; Wise-Harris et al., 2016) and use of EDs by individuals with mental health needs is often reported to be ‘inappropriate,’ or an ‘abuse’ of the system (Wellin et al., 1987; Wise-Harris et al., 2016). Along with individuals being seen to ‘misuse’ the ED for mental health needs, are allegations of noncompliance with treatment or medication leading to higher rates of ED use (Young et al., 2005).

The ED is a less than ideal destination for individuals with mental health needs, however it fills a gap where other options do not exist or are not accessible. From paramedic accounts, frustrations with the ED as the receiving facility for individuals with mental health needs exist for ED staff, paramedics and the individuals in distress. ED staff may be overwhelmed with

other medical and trauma emergencies and paramedics described being frustrated with limited options for transportation of patients with mental health needs. This raises important questions: Do individuals needing mental health support receive inadequate or insufficient support in the ED? Are there other services that could better serve individuals with urgent or emergent mental health needs? Can paramedics transport individuals to other more appropriate mental health support services?

While frustrations exist, critiques of ED use for mental health are problematic as they often focus on the level of the individual and blame the victim (Ryan, 1971) and disregard the contextual, systemic factors, which result in ED use (Ford-Jones & Chaufan, 2017). A predominant biomedical framing of mental health issues in medical settings places emphasis on medication compliance and psychiatric evaluation rather than non-medical mental health and social care supports not delivered by physicians. As discussed in Chapter 2, while biomedical framings of mental health may be useful at times (McGruder, 2002), and while not rejecting *any* role of biology, to focus solely on this, disregards the social context, forms of oppression and social injustice creating distress (Morrow & Weisser, 2012). Addressing only the symptoms of distress with medication and treatment fails to address the causes and circumstances creating distress (Mills, 2015). In the case of medication or treatment non-compliance, whether or not an individual's prescribed medications are in fact appropriate is not questioned. Also not questioned, is the reality of the individual's experience of side effects or other negative issues associated with psychotropic medication use (Whitaker, 2010). While not negating the value of medication for some individuals in certain circumstances, they are often overemphasized, with less opportunity for other types of support such as counselling or other talking therapies (frequently not covered by public funding), as well as community supports which address broader social needs.

Paramedics identified many individuals with complex social, economic and other living circumstances that appear to be contributing to distress. These are essentially reasonable responses to abnormal experiences, resulting in distress. Biomedical understandings and treatment settings for mental health and 'mental illness' run the risk of discounting this context and the supports that may be most beneficial for individuals in distress. When we discuss gaps in community mental health supports, this refers not only to insufficient access to psychiatric support, but inadequate comprehensive mental health and related social care services to

appropriately support individuals' mental health needs both preventatively as well as when distress or crisis arises. Discussion of mental health needs as 'inappropriate' use of the ED, places this issue at the individual level and fails to account for whether or not appropriate, accessible, alternative services in the community exist for individuals seeking help, as well as other social, political, and economic factors creating distress, leading to the need for assistance. Many positive community mental health supports exist, but may be at capacity and functioning as silos (Wiktorowicz 2005; Wiktorowicz et al., 2010). Many counsellors and psychotherapists provide support and methods for coping with challenging circumstances, but are costly for individuals or have limited availability. Many community social supports that support good mental health, decrease social isolation and increase social supports exist. These may however receive limited public funding, be overtaxed and may be poorly connected to other parts of the system and thus difficult for families to navigate.

Feminist political economy analyses the structural constraints and ways in which care is provided (Armstrong et al., 2001). The ED exists within the health system, which exists as one such structure, impacting the care provided to individuals in distress via paramedic services. While there may be difficulties within the ED, is there another option? Paramedics provided accounts of challenges and limitations that exist in providing care to individuals with mental health needs. The context of the ED as a destination for paramedic services transporting individuals with mental health needs, presents a variety of challenges. Challenges include: long wait times, poor conditions in which to wait, staff with limited time and training in mental health needs, in a system already overwhelmed with medical and trauma emergencies that may present as more "urgent" than mental health needs, as well as a lack of constructive resources and supports in ED for those with mental health needs. It is difficult for paramedics to continue to attempt to encourage individuals on scene to go with them to hospital to seek further support. Tensions exist as the ED is one of the only available options for individuals with mental health needs, but a far from ideal destination for them. As presented in Chapter 5, the legislation directs paramedics to transfer individuals to ED; however, with changes in legislation and a number of pilot programs, there is room for a shift in possibilities for transport destinations for mental health needs, as will be further explored in Chapter 9.

7.6.5 Urban and rural service provision

This chapter presents the experiences of paramedics attending to mental health and psychosocial needs in both urban and rural settings, as well as some of the related circumstances on the scenes of these calls. Both rural and urban communities present unique circumstances and contexts for paramedics providing care and for individuals experiencing distress and with mental health needs. It has been a failure of policy-makers to not appropriately differentiate rural and urban mental health needs such that they may be adequately and appropriately addressed (Milligan, 2005) and it is necessary to explore the differences in these needs for paramedic services providing this type of care.

Paramedics identified a high proportion of mental health-related calls in urban areas. Milligan (2005) notes that many individuals with mental health needs may seek supports in urban areas due to inadequate community mental health services in other areas. Urban areas may offer a sense of inclusion for those with mental health needs with the existence of more available and accessible 'semi-institutional' facilities such as drop-ins (Parr, Philo & Burns, 2004). Additionally, urban settings may offer – even for those originally from more rural locations – greater anonymity in a larger population where individuals seek to avoid stigma and support services which may be less readily available in rural areas with a widely dispersed population (Milligan, 2005). While, urban centres can offer anonymity, and less geographic and social isolation (Milligan, 2005), it does not mean it is non-existent in urban settings. This isolation may result from attitudes, perceptions and political decisions that push those with mental health problem into more marginalized inner-city neighbourhoods (Parr et al., 2004). One paramedic identified, despite being surrounded by more people, those with mental health needs may still feel isolated (Interview 005, 2018).

Mental health and psychosocial calls, are frequent and may make up a substantial component of urban paramedic work. This frequent interaction, despite urban centres being theoretically an area of more concentrated mental health and social services capacity, identifies a gap resulting in unmet mental health and psychosocial needs and a large number of calls to paramedic services. This call volume has implications for urban paramedic care providers, often overloaded with this call type. Paramedics expressed frustration about the limited ways they can provide care on these calls, and certainly for the individuals requiring care who have to default to emergency services when other services are not meeting their needs. While urban services may have a greater number of ambulances and paramedics, they serve larger populations and are not

necessarily better funded per capita than smaller services. Mental health calls specifically, as discussed, have received low priority and little focus within all paramedic services, and as such resources for managing this type of calls are not necessarily more present in urban services.

There are differences with rural mental health care as it involves paramedics. Substantial variation exists in what is defined as rural, and as such, it can be problematic to make summarizing claims about experiences of health in rural communities (Smith, Humphreys & Wilson, 2008). Similarly it is problematic to comprehensively summarize in any one way, the experiences of mental health in rural areas as these are not necessarily experienced in one way (Philo, Parr & Burns, 2003). Despite this variation, there are a number of considerations that have been found to be relevant in rural communities. Considerations for health equity in rural communities include the nature and level of what services are available and ability to access these services, as well as other determinants of health impacted by rurality (Smith et al., 2008). Potential conditions in rural communities that may impact mental health and distress include geographic isolation, limited access to resources, stigma, and more traditional belief systems (Letvak, 2002). Other factors include potentially difficult economic and social circumstances as well as traditions of self-reliance, which means individuals may aim to manage their concerns on their own rather than seeking health or mental health supports (Fuller, Edwards, Procter & Moss, 2000). Additionally, lack of social support and isolation have been identified as factors impacting mental health needs in rural communities (Findaly, 2003; Letvak, 2002; Parr, Philo & Burns, 2004). Experiences of isolation may be more pronounced in rural or remote communities and may be greater than that of those in urban communities, where there may at least be inclusion amongst other mental health service users (Parr et al., 2004).

Lack of attention to the specific mental health needs in the rural setting is thought to be associated with poorly dispersed mental health services (Milligan, 2005). Importantly the social and other contextual factors impacting mental health in rural communities have been poorly understood and as such, inadequately accounted for in community mental health services (ibid). Responsibility for managing mental health needs in rural or remote communities often falls to the local general health system such as General Practitioners (GPs), and substantial distances and inconvenience are typically involved with specialist mental health services, often where transit is limited (Parr & Philo, 2003). This limited access to specialized mental health services and reliance on general health practitioners presents concerns for the level of training and

qualification for managing mental health specific needs as well as appropriate treatment options with concern for a reliance on medications for treatment which might be managed with other forms of support or therapy in other contexts (Parr & Philo, 2003). Challenges exist for rural and remote communities in establishing equitable yet cost-effective mental health services and supports for a wide-spread population requires policy makers' attention to shift beyond urban-based health needs (Milligan, 2005).

Research on paramedics providing care in rural communities is limited. Paramedics have however been identified as playing specific roles in care provision in these communities. In speaking of paramedics in a rural community program in Ontario, Martin, O'Meara & Farmer (2016) identify that "...paramedics are increasingly providing basic assessment, treatment and referral to appropriate health and community services. This is evident with seniors and medically vulnerable residents in rural communities, where health workforce shortages result in paramedic services filling essential primary health care service gaps" (pg. 278). In the Australian context, rural paramedics have played unique roles in care beyond prehospital emergency care and have been involved in interprofessional collaborations in the hospital and community setting, much of which has occurred informally (Mulholland et al., 2009; Stirling et al., 2007). It appears that mental health and psychosocial needs may be presenting as an additional service gap existent in rural communities, with paramedic services acting as one service temporarily, even if sometimes inadequately filling the gap. There is limited literature on the role of other emergency services addressing rural care gaps; however, in the Australian context, Bradbury, Ireland & Stasa (2014) found police contact intensified for those with mental health needs in rural settings. Similarly, in interviews conducted for this study, paramedics in two rural services stated that police often play a role in their mental health calls, and may sometimes have more frequent contact than they do with individuals with mental health needs in small towns (Interview 006, 2017 & Interview 028, 2018). Paramedics in some services mentioned that fire services attend their calls, however they are not intended for these type of calls, and would not be sent without paramedic services also being tiered. Additionally, fire services in many rural communities are volunteer and are unlikely to be tiered to mental health and psychosocial calls.

As the example of a patient (Jill) with mental health needs in a rural setting demonstrates, there are substantial challenges that exist in terms of care provision in a rural ED receiving

facility with few or no other timely and accessible mental health care options resulting in a lengthy process of transferring the patient to another destination. Ultimately, during this transfer, the patient remained in the care of the hospital staff and paramedics were only there providing transportation and assistance in managing. The transfer demonstrates the tension of providing care when paramedics have been advised by hospital staff of the significant violent tendency of the patient, feel the need to protect their own safety, (in this case, the potential for the patient to rock the stretcher requiring the paramedics to ensure it would not tip over). By the same token, the hospital staff emphasis on safety and the dangerousness of this patient undoubtedly effected the care this patient received. At the time of the transfer, it appeared that the patient was receiving nothing in the way of mental health support but was truly being “managed” while getting to the next hospital. I did not observe the initial interaction of the patient and hospital staff, or have exposure to the prior history of the patient in that ED. The report by the nursing staff and physician however indicated that both played a substantial role in how this patient was managed. Addressing safety remained paramount in this situation, and while critical, it undoubtedly raises concerns for the degree of actual mental health support and generally supportive care that Jill was receiving versus only a focus on managing safety. Safety was one important element of Jill’s care that needed to be attended to, both for her wellbeing and the wellbeing of the staff. There did however appear to be substantial gaps in care and emotional support for Jill, as well as efforts at de-escalating Jill’s distress and agitation.

Reflectively, this call seemed to highlight so strongly the tensions between ensuring the safety of paramedics and ED staff, as well as the patient, and receiving appropriate and supportive care. In my experience as a paramedic and through my observations, it seems that the need to ensure safety often trumps the need for supportive care in many situations. This is generally not done callously and uncaringly, but is based in prior experience with an individual or particular scenario. Many patients with mental health needs often seem to be lumped into the same category of being a safety concern. Many paramedics - - managing situations in which people (not just people with mental health needs) become violent, and in which they must then manage the consequences of that aggression or violence - - are inclined to act proactively, arriving on scene, focused on the possibility or likelihood of violence.

It is worth considering that when mental health needs are being addressed in unconventional, community settings, responsibility for care is also falling to those not formally

trained and with limited or no expertise in managing and supporting these needs. As care has been shifted onto the community and gaps are filled by paramedic services where other appropriate, formalized, mental health supports and services are lacking, there may be less likelihood of managing mental health needs in a supportive way, without focusing primarily on issues of violence and safety. Furthermore, the place of care, such as a rural setting, in which an individual in crisis may have a lengthy wait time before receiving proper mental health support even via ambulance, may exacerbate distress and increase legitimate concerns for issues of safety for both patients and paramedics alike.

Additionally, as will be further discussed in Chapter 8 – a lack of training and tools in managing crises and mental health, limits the options and means for managing these calls in all paramedic settings in Ontario. From the patient perspective, many individuals with mental health needs, as noted above, are often the subject of violence rather than the perpetrator of it, and as such may have understandable apprehension with encountering people in uniform. These individuals are in a state of distress and/or a state of acute stress response. It seems warranted to question whether there may in many situations be alternative de-escalation methods in combination with supportive care for individuals in distress, ensuring that the care of the person in distress is kept at the forefront of the interaction along with safety.

7.7 Conclusion

The sites in this ethnographic case of mental health and psychosocial calls in paramedicine in Ontario show that mental health needs exist across a range of settings. Mental health needs were identified in urban, rural and remote settings, with similar challenges with home and community care, the ED as a primary destination for mental health needs, safety and violence concerns and with paramedics providing care in all of these settings, often filling unaddressed gaps in other services. Additionally, observations and interviews in both urban and rural settings highlight that the mental health needs and conditions of work and care differ between urban and rural settings, and should be treated differently by the health care system and policy makers.

In this chapter, I presented the contexts and conditions in which mental health calls occur, and the tensions that exist in this dynamic. Given these contexts and conditions under which work and care unfold, there are inherent limitations in the ways care is provided and received.

The structural limitations challenge care provision in the prehospital, community setting because the ED is the only destination for individuals with mental health needs. These structural limits on the conditions of work and care draw attention to the contexts directing and restricting paramedics' ability to provide appropriate, supportive care on mental health calls.

Chapter 8: Training and Education

8.0 Introduction

In order to understand the ways in which mental health calls are managed by paramedics, this dissertation set out to explore mental health education and training for paramedics. Along with policies and guidelines, training and education are other elements guiding paramedic practice. The priority that mental health-related education and training has taken, is largely reflective of the origins of paramedicine as well as the biomedical paradigm found in paramedicine with training focused on acute, urgent physical health issues (Williams, 2012). As the nature of calls received by paramedic services has changed to include increasing psychosocial and mental health components (Brady, 2012), there is a need to assess training received for these components of care (Emond et al., 2019; Williams, 2012).

This chapter explores training and education in mental health care in paramedicine, the extent to which there is training in this field, and whether further training might be of benefit. First I describe paramedic education and training for mental health care in paramedicine in Ontario. I then explore paramedics' experience with this training, the perspectives of educators in Ontario college paramedic programs and ongoing, and continuing education in this area. This chapter identifies some of the promising practices existing in paramedic student and front line paramedic education. Using a feminist political economy analysis, I discuss the gaps in training, the role of experiential education and preceptors, the importance of continuing education and why mental health and psychosocial calls may receive less emphasis in education and training. I analyze this training within a broader context through the lens of gendered work, and the value placed on different kinds of work; the role of 9-1-1 services in "care" provision, and the limits of education and training.

8.1 Paramedic education

As outlined in Chapter 4, in order to practice as a paramedic in Ontario, a paramedic must have successfully completed a paramedic program at the college level (Ambulance Act, 1990). Paramedic training in Ontario is standardized by the Ministry of Training, Colleges and Universities for primary care paramedics (PCPs) and advanced care paramedics (ACPs). Critical care paramedics (CCPs) are trained through Ornge. I will focus on describing PCPs, the

minimum level to which all paramedics in Ontario are trained, and the greatest proportion of front line paramedics in Ontario (approximately 80%) (MOHLTC, 2018). College paramedic programs for PCPs are most commonly two years in length (OPA, 2018) but may be less than two years. Training includes in-class didactic, hands-on skills courses, physical fitness and lifting training as well as clinical components (both in hospital placements and on the road – on ambulance placement) (Ontario Colleges, 2018).

The expectations for clinical competence from paramedics has increased as the scope of practice has evolved since it was established as a field of health care. Those entering the profession are expected to be prepared for independent practice (Tavares, Boet, Theriault, Mallette & Eva, 2013). Academic literature around paramedic education and training for mental health calls is limited. Some literature on paramedic training around mental health calls exists from the UK, USA, and Australia, where notably different education systems exist, some of which involve an undergraduate, university education. One study of paramedic textbooks for accredited training paramedic programs in the U.S. identified that the extent to which they address behavioural health emergency management by paramedics is insufficient (Donnelly, Cameron, Bucciachio & Tong, 2018). In an Australian study of paramedics' perceptions of providing care for those with mental health needs, McCann et al., (2018) identified the need for greater education and in-service training in order to address paramedic concerns about their expanding scope of practice for these type of patients. Related literature confirms that this is an area under-addressed in paramedic training (Emond, Furness & Deacon-Crouch, 2015; McNamara, 2016; Williams, 2012). Additionally, in the Australian context, Shaban (2005a) found that “no rigorous theoretical model for the mental health assessment of patients in ambulance care could be located and no published research supporting any such investigation could be located” (p. 2) when reviewing models of assessment for mental health calls. This lack of standardized mental health assessment in paramedicine practice internationally indicates little standardized mental health assessments incorporated into paramedic training.

8.1.1 Provincial requirements for paramedic training

The *Paramedic Program Standard* (2008), published by the Ontario Ministry of Training, Colleges and Universities, outlines the program standards for colleges across the province that are training paramedics. The document includes vocational standards, essential

employability skills, and general education requirements, established with the intention of bringing greater consistency to college programming across the province. These standards must be met by colleges offering paramedic programs. The standards provide broad guidelines, directing paramedic training with the specific program layout and course content varying from college to college.

Throughout the *Standard*, there are a number of learning outcomes related to mental health or to providing care on a mental health-related call including: effective communication and inclusion of social and psychological information into assessment findings (Table 1). The *Standard* also includes several outcomes related to paramedic mental health (Table 2). Finally, the standard includes a list of themes, intended to guide the development and identification of courses fulfilling the general education requirements. The themes include suggestions of which topics might be included, but it is “neither prescriptive nor exhaustive” (p.26). Themes include: arts and society; civic life; social and cultural understanding; personal understanding; and science and technology. The theme of personal understanding provided is most relevant to mental health-related content paramedic trainees address in understanding of themselves as “psychological entities” (p.27) as well as understandings around human social behaviour.

Figure 8.1 Learning Outcomes Relevant to Providing Care for Mental Health Calls

| Learning Outcomes Relevant to Providing Care for Mental Health Calls |
|---|
| “employ communication interventions that contribute to patient’s optimal well-being” (p. 7) |
| “utilize a non-judgmental, empathetic, respectful, honest, and genuine approach to communications” (p.7) |
| “adapt communication technique based on factors influencing patient and family communication; e.g., age, capacity, comprehension level, and ethno-cultural practices” (p.7) |
| “use appropriate communication techniques with patient, family, and bystanders in stressful situations” (p.7) |
| “respect and value patients from diverse backgrounds” (p.7) |
| “apply conflict resolution skills” (p. 7) |
| “interpret and prioritize changes in patient assessment findings based on physiological compensatory mechanisms and psychological coping behaviours” (p.9) |
| “determine the impact that the patient’s psychosomatic presentation and external influences may have on assessment findings” (p.9) |
| “explain reassessment findings using pathophysiological and sociopsychological theories (p.12) |

Drawn from the *Paramedic Program Standard – Ministry of Training, Colleges and Universities, June 2008*

Figure 8.2 Learning Outcomes Relevant to Paramedics’ Own Mental Health

| Learning Outcomes Relevant to Paramedics’ Own Mental Health |
|---|
| “identify factors that may lead to critical incident stress” (p.14) |
| “recognize critical incident stress in self and others, and act or seek assistance to remedy” (p.14) |
| “employ personal care strategies to promote own physical and mental health and to minimize the potential for injury, illness, and professional related stress” (p.14) |

Drawn from the *Paramedic Program Standard – Ministry of Training, Colleges and Universities, June 2008*

In this current standard, there is not specific training for mental health calls, care provision for individuals with mental health needs, or specific requirements that must be met. As will be addressed in the subsequent sections – this leaves training around mental health calls for paramedics open to interpretation and at the discretion of the paramedic program and college. Ultimately, variation exists from college to college in what training is included with regard to mental health-related calls.

8.2 Paramedic perspectives on mental health training

First and foremost, paramedics identified that their training focuses primarily on medical and trauma emergencies, with significantly less focus on other call types including mental health. One paramedic with 5 years’ experience described the training in this area:

It’s hard because we don’t have a tonne of training on it {mental health} which like... very, very little in my opinion. So you just kind of– because we’re normally dealing with their physical injury as opposed to the mental health part of it but... just be there for them to talk to if they’re wanting to talk to you

(Front-line paramedic Interview 024, 2018)

Paramedics – with a range of experience -- spoke of their training. Some very recently completed their college training, while others were more than 30 years away from their college training. The response regarding the amount of content related to mental health however, was quite similar regardless of years of training. One paramedic of nearly 30 years’ experience stated:

So initially, I went to, I went to college when it was still a one-year program. So in one year we were taught everything you’re supposed to know from pediatrics to

geriatrics and all points in between, so the amount of mental health treatment and training that we received then was quite minimal.

(Front-line paramedic: Interview 005, 2017)

Another paramedic who had been working less than 6 months as a front-line paramedic stated:

But, the tricky thing is, with it being such a condensed program and having to learn the entire medical expertise in such a short time, a lot of focus is shifted away from mental health and more in the medical emergencies... So a lot of it is kind of making it up as you go along and trying to figure out what goes well and what doesn't go well and applying that to your next call.

(Front-line paramedic: Interview 030, 2018)

A challenge paramedics identified was having sufficient time in the program to cover mental health-related content. They expressed concern that the amount of content and skill development required was condensed into a two-year program. Paramedics felt that as a result, mental health is afforded less prominence in terms of time and focus because of the already significant demands due to the amount of content to be mastered. As well, given the evolution of the nature of calls received by paramedic services, front-line paramedics stated there is a need for training to reflect these changes.

Because realistically, in our college, 'cause our program's two years ... It should realistically be four years because it's a lot of information compact into two years and our scope of practice and our patient demographic is a lot...different than what it used to be. It's no longer throwing somebody in the back of the vehicle and driving them to the hospital. It's more dynamic and fluid, there's a lot more subtleties, nuances to the...to the calls. I mean a lot of what we're taught is, you know, be an active listener. We're taught the...I'm gonna call them the sexy mental illnesses. How to recognize them but not really how to manage them. Basically, if you feel unsafe, let police take over. If there's somebody that you feel needs to be formed, go down that avenue. Just talk to them, be empathetic, that sort of thing.

(Front-line paramedic: Interview 002, 2017)

Ultimately, paramedics referred to the experience they gain on the road as their primary learning experience. Paramedics spoke of having limited time to learn in the classroom as well as being

dependent on the types of calls seen on the road as a student and their preceptor's level of engagement with mental health calls. Paramedics often spoke of the variation and nuances of mental health calls as something that requires significant practical learning and often has the feeling of being self-taught.

Because that's a whole realm of things that are going on, unless you've seen before you really...so as a new medic just coming in on the street, you have no idea how to deal with it, because you're not taught in school. Now, I shouldn't say that. I'm not in the system as far as school. But I've seen enough students come out in thirty-three years that they're really not taught how to deal with mental health issues other than the simple... "You're picking up Joe whose got, you know depression, from the park and he's homeless," that's, you know, "what are you gonna do?" And they teach them how to treat them physically. But the other of those things where you walk in and there's...there's a fight going on between the eighteen-year-old whose living at home with bipolar disease who won't take his medications and the parents are wanting to take him to the hospital but he's saying no and he's eighteen so he's legal and he's fully alert and oriented, has the right to refuse. Now the parents are yelling at you. That's just experience. That's just defusing a bomb and learning how to do that, and knowing what agencies to call...I have the years of experience, but it's not what I'm trained in. It's self-training unfortunately, just because of the volume of calls

(Front-line paramedic: Interview 003, 2018)

Paramedics spoke of mental health calls being such "grey area" that standardized, formalized training would be a challenge. Along with this, some paramedics identified that providing care in this area was not something they had expected and not why they were getting into the job.

I do wish that the portion that's taught in college when you're going through school to become a paramedic was a bit more substantial. Although I have sympathy towards people who are suffering from mental health conditions and I have no problem speaking to them and bringing them to the assistance that they want, it's not a type of work I would want to do. I wouldn't go to school to become a psychiatrist, it doesn't, that doesn't interest me. So...I want to have enough {training} to do my job properly and because my job is so varied there's many different facets that I have to look at, but I don't necessarily just want to concentrate on mental health... But I, I find it just so frustrating that b-...I can see when I put a bandage on

somebody, the bleeding stops. I can see when somebody has a broken leg and I've realigned it, and I have it splinted and it still, I can see the relief on their face. But you can never really tell whether any of the treatment's working on the inside. And that's a difficult one.

(Front-line paramedic: Interview 005, 2017)

Several paramedics who trained in one southern Ontario college program, stated that while they wish they had more training and still felt it to be insufficient, they had a really positive learning experience with their mental health-related training. This included in-class scenarios, a crisis intervention focused course, a clinical placement in a mental health-specific facility, and a course instructor both with mental health experience as well as experience with first responders.

We actually had one instructor {name}, who was fantastic and {they} sort of made it a huge point to teach us mental health and like a lot of the scenarios you have in school are giving medication and you know, treating a trauma where as I said before, that's maybe 20%... that's a generous number right? Of your calls. {The instructor} ensured we had like tonnes of communication scenarios, just talking to people who were suicidal or you know, going into a high school. I remember one scenario and there was a young girl and she had been doing meth and at the time I never thought of it but that's a real world scenario right? That's sort of a higher percentage of calls you're gonna get. So {the instructor} made it a big point of {theirs} to really incorporate that into our program which was fantastic. We also had a crisis intervention course, which was amazing. We had the sweetest teacher ever. I think it was like two hours a week maybe we had that class but, yeah that's all we would talk about, crisis intervention right? And so a bulk of it was mental health and {they} told us how to deal with and brought in lots of speakers that could talk to us like, this is a program we do for this, and this is a program we do for that. So it was really nice, {they} sort of opened our eyes before we got out into the real world of like what we're going to see and sort of what we can do to help. So like if somebody asks me about a women's shelter or something like that or you know, human trafficking, it's like I've learned so much now that I feel like I could really give some decent advice, like obviously not fantastic, it was only a couple hours a week, but it's like, it was definitely helpful. 'Cause I don't know how other schools go about that and I know that like being hired, you don't really sort of train on that

kind of stuff, so I think that like, I'm happy that {college name} had sort of prepared me for that aspect (laughs).

(Front-line paramedic: Interview 004, 2017)

8.3 College instructors' perspectives on training

Paramedic program instructors discussed the training provided for paramedic students, acknowledging variation in training from college to college and instructor to instructor. Instructors described the bulk of mental health-related education being delivered in an introductory psychology course, geared to some extent toward paramedics, or in a crisis intervention type of course, often with 1-2 semesters for the course. They identified a didactic portion of training, something minimal, but generally focused on identifying the major Diagnostic and Statistical Manual (DSM) diagnoses, as well as skills and scenario training with some scenarios focused on communication and management of mental health calls. While one program stated that students receive a clinical rotation in a mental health specific facility, other instructors stated that some type of practical experience in a mental health-related service or facility would be of benefit to students, but is not currently a component of their curricula.

All college instructors described that there is too little mental health-related experience and training for paramedic students. They indicated that lack of education in this area has implications for students' ability to manage mental health related calls on the road, especially when beginning work as a paramedic.

It {mental health training} has to be considered as important as anatomy physiology and pathophysiology. Students need to be able to take what they learn and apply it in a practical way. At least to give them a basic understanding and a basic comfort level, with dealing with patients in crisis. Yeah, we're taught how to learn how to deal with a person who's unconscious and they've overdosed. Simple. Totally easy call to do. But, when you have somebody who's walking and talking, it's a little more difficult. Training there. So, that would be expanding the didactic portion of paramedic training, as well as the lab, or, practical training, to include a very intensive mental health component. Part of their clinical, as a student, I think, should be mental health.

(Paramedic educator: Interview 040, 2018)

Instructors in paramedic programs come from varied educational and experiential backgrounds. Some have direct experience with first responders, some with primarily psychology or psychiatry or with other counselling experience, and some with experience primarily as a paramedic with little to no mental health-specific training. Instructors identified that along with the variability in mental health curricular content, there was variability in instructors' experiences and the relevance of their background for paramedic work.

Well I think this {training} is where we have some shortcomings. In my opinion the trouble with community college level paramedic training is that the person who ends up teaching subjects like crisis intervention and understanding of mental health are typically not experts. They're typically paramedics who have experience in the field who have anecdotes that they can share who have – who do lit searches and do their best to convey accurate information and to help students understand mental health and how to deal with it. But of course from college to college you'll get inconsistencies, for example we have an instructor now who has a degree in psychology and he has a keen interest in mental health and I believe he's very good and he brings in some guest speaker experts, but prior to him we had someone who had very little expertise, if any, and prior to that no expertise. So it's largely inconsistent and I suspect it's probably the same across all community colleges that the person who's teaching in that area may be fulltime and may have some expertise in other content area but not mental health, or they have part-time staff filling in that position and so they may have someone who's pretty good at it one year and not so good at the next year and terrible the third year (*laughs*).

(Paramedic educator: Interview 041, 2018)

There was not only variation in instructor training and expertise but also in course content. At times, mental health was poorly integrated into the rest of paramedic practice. One educator describes that certain specific elements of training, such as suicide risk assessments, were done very well, however in other areas such as psychosocial issues, training was not done as well. Furthermore, even when training was done well in one area, it was being learned in isolation from the rest of paramedic practice.

So speaking from the education side, I mean they {the courses} do speak to mental health calls but they speak to, again I'm going to go to the very apparent management of mental health calls where, I don't know if my chosen words are

correct there, but almost the stereotypical call. You know, you have the agitated patient, they're swearing and yelling at you or there's clearly a paranoid schizophrenic or somebody on scene, I think there they {the paramedic students} speak very well and they do apply some management systems and suggestions. I think that's where they're good. I think again where you have a patient that is overtly threatening suicide I think they can definitely do a suicide risk assessment. I think there is enough in the objectives to speak to that. Where I don't think it prepares students is in the non-obvious mental health call or the call where psychosocial factors are probably impacting that patient, and we're just not picking up. Or it is not part of our perspective or understanding to even look for them. So I think they are missing that factor and I think they're missing that factor that we're not, that I think paramedic education sometimes has to be to make us that jack-of-all-trades for lack of a better word. I think we're taught to manage things in silos. Then the other piece I think I'll say about these calls and the education for these calls is that we do it sometimes with an expert. And so the psychologist, or somebody that is an expert in psychology, we send them to that course. There you go - you have psychology. It's learned in a silo, I don't know if it's integrated well as well into the rest of the program and I think we could do a better job of that as well.

(Paramedic educator and front-line paramedic: Interview 036, 2018)

Along with a need for an expanded mental health-related experiential component of training, a need for broader understanding of both psychosocial stressors and needs was identified, as well as the need for more standardized assessment tools suited to the prehospital paramedic services setting. While standardized questions around self-harm or harm to others have been incorporated into the BLS, and instructors identified this to be a component of curricula, assessment tools for other forms of supports and services are thought to be needed.

Instructors also stated that students' own mental health is an increasing and necessary component of paramedic student training around mental health. They discussed that student mental health and wellbeing are increasingly being included in the course content, but that additional focus would be of benefit.

So, I really try to get the students to think about what are those points in your life? How does stress show up for you? Who in your life notices and is able to tap you on the shoulder and then what do you do with that with stress and how you manage it

better and so and so on and so forth. But to deepen that understanding, that knowledge. Well, it would be fantastic if you would be able to if somehow, we could do that as an ongoing process in the second year as well... I think that would be really valuable. Also, to do a check-in on their mental wellness. And how the work has impacted them and also talk about, you know, what strategies they have going forward. Now, with a little bit of a more realistic lens because we've now been doing their ride outs for that period of time. I think that would be really, really, really valuable.

(Paramedic educator: Interview 039, 2018)

Educators remarked on how the need for expanded mental health-related training is increasing and hope that growth in this area will continue.

I mean I think there's definitely room for improvement. I think we've come a long way within the programme. We have identified the need for communication scenarios. It's not always about mental health per se, but I think it's definitely opened up the students' eyes and forced our hand to come up with these tools to educate them on how to deal with these patients, how to communicate properly whether it's a death notification or you're dealing with a terminally ill patient or someone who's agitated, etcetera. So I feel like we've come a long way. There's still a very much longer way to go and yeah, I think as we continue to grow with maybe the psych courses and the psych profs and amalgamating some of the content or sharing objectives and goals, maybe that will come to fruition in the next couple of years.

(Paramedic educator and front-line paramedic: Interview 036, 2018)

Upon providing their Ministry curricular content for this study, a few paramedic educators pointed out that the curricula is currently under revision and the length of their program is being expanded. In these curricular shifts, and as colleges adapt the curricula to their specific program, there is potential for inclusion of additional mental health-related content.

8.4 Continuing medical education and ongoing training

Along with the initial training received by paramedic students, I wanted to determine the extent of on-going mental health-related training received by working paramedics at the paramedic services level. Continuing medical education (CME) for paramedics is ongoing

training to maintain or enhance knowledge and skillsets provided by paramedic services themselves as well as Base Hospitals (see Chapter 4 for further discussion of the role of Base Hospitals). CME sessions may be mandatory - - required by all paramedics of a certain training level to maintain or update skillset - - or some CME sessions may be optional, whereby paramedics receive educational credits for completing training but it is not required. Paramedics may or may not be financially compensated for attending these sessions. It is via CMEs, either through the paramedic service or Base Hospital that paramedics would receive any formalized, ongoing training related to mental health calls.

Base Hospital managers and physicians stated that there is limited time for the range of necessary content to be covered in CME. There are general updates needed to maintain paramedic scope of practice, such as updates with medication delivery and technical skills, following which other areas of focus may be added in. One Base Hospital physician in Ontario stated:

I think training and education and ongoing education about these patients {mental health patients} ...some of it is certainly limited by the restrictions we have on training hours for paramedics. I think that is huge. I've been advocating for another eight hours for PCP for many years, maybe getting there. But I think the lack of training hours from both the service perspective and the base hospitals really handcuffs you to be able to update paramedics on mental health issues. So many other things come through, you know, we have to ensure that from the Base Hospital perspective that all of the directives with medical directives with the protocols and those fall under the quality assurance programs and education, and then you run out of time. So, to be quite honest, mental health does fall behind and there's not nearly enough education hours to be able to really give good ongoing CME to paramedics for mental health

(Base Hospital Physician: Interview 044, 2018)

One Base Hospital physician pointed out that it is often only when a particular, acute issue arises that it becomes priority for delivery in CME, as there are many competing content priorities.

The opioid crisis was a good example, you know, although we got to changing the Narcan directive and things like that for them {paramedics} being able to help those patients, still there wasn't a lot of room for further education on those patients. I

think that's important, you know, seeing more people with depression – and I'll go back to the indigenous population once again... I think that's an important thing in our areas. There's not a lot of education they {paramedics} have received on that, and again, with indigenous people it is different and their needs are different. The resources are different. And how do you manage the patient, even in the prehospital care setting is somewhat different too.

(Base Hospital Physician: Interview 044, 2018)

When asked about ongoing training or CME content related to mental health calls, paramedics indicated varying amounts of training over their years of experience. Many identified little or no additional mental health-related training throughout their time as a paramedic. Training received around mental health calls was described as sporadic.

There's not a whole lot here, there was a lot more in {name of an urban service} where we had a lot of in-session training. We'll have the odd PowerPoint here, but the education here is not remotely close to what they have in {name of urban service}, and I say this they have a better, bigger budget I would assume too, that might go along with it.

(Front-line paramedic: Interview 014, 2018)

One paramedic also stated that most frequently the ongoing training related to mental health involves their *own* mental health.

I think that we have had, I'm trying to think in the past... I think we might have had a short, like maybe a thirty-minute, video that we watched that was covered in our training... (*pause*) but I can't think of anything. We haven't done a tonne to be honest. I feel like in the profession, there's things coming through like with social media and stuff, like IVEGOTYOURBACK and that type of thing that's kind of making it more of an accepted thing. But I definitely think we could all use more training... in all areas

(Front-line paramedic: Interview 005, 2017)

8.5 Promising practices for training with mental health calls

As paramedics discussed their experiences with education and training, they identified positive experiences as well as what additional areas they would like to be included. Requests

focused broadly around more training in the form of both knowledge around mental health as well as applicable skills for managing calls. Promising practices occurring in some services identified by participants addressed a number of current training shortcomings, and presented new means of educating in this field.

8.5.1 Access to information resources

Many paramedics identified that increased knowledge and discussion about mental health is happening outside of the field of paramedicine but ought to be tied in to paramedic training and education.

Yeah, I'd like to see someone like you come in and do like an annual CME on the changes of mental health, or different approaches that may have been discovered over the years, on how to approach, a Form 1 aggressive patient versus a depressed case, versus an Alzheimer's/dementia, or something like that. 'Cause I think we more or less just go on what our best guess is...I think if we had some more, maybe just understanding of mental health... and it's coming, I can see it coming. I think it's an overall, I'm not gonna blame our service by any means, I'm not gonna...I just think it's an overall kind of enlightenment on mental health in the province and the country right now, on how to deal with it... So education would be one big piece of it.

(Front-line paramedics: Interview 014, 2018)

Paramedics also spoke of wishing they had more information and resources about what services they can offer on scene or direct people to, for individuals in distress as well as information about the process of care at the receiving facility with regard to mental health needs. Several paramedics indicated it might be useful to have someone from the hospital's Crisis Team speak to paramedics, to describe their process and help ease the transition to hospital. The mental health and substance use call I observed with Beth and Terry, described in Chapter 4 - - an experienced crew - - they spoke at length about their desire for more information to be able to present to patients:

They said what they really want to know is what is the actual outcome for patients going in to emerg. They want more info for medics so medics really know what they're telling the patient. They said, they were encouraging this guy to come {to

hospital}, and trying to tell him about the help he'll get at the hospital, but honestly, they don't really know what kind of support he'll actually get there or what the process is at the hospital. They said it would be really helpful to know what services we (EMS/hospital) can actually offer and what they actually look like so they are providing accurate info. Even phone numbers for example. They said they want to feel we can honestly provide information to patients. This was an interesting discussion with a highly experienced and seemingly thoughtful crew, and informative to know that even a crew such as this felt that they truly didn't have a clear picture of what the process looks like for mental health patients at hospital, what services are really offered. I thought that this seemed like an important piece to make note of, and potentially an important piece in report back to paramedic services.

(Field Notes, 2017)

Paramedics identified the need for more extensive courses of longer duration on mental health in order to have time to gain a fuller understanding.

I guess the full-year length would have been much better because psychology is such a huge part of our role as paramedics because learning people is what we really have to do. If you can't really understand mental health issues you can't really treat them either. We were trained a lot in health issues with physical health and everything. There was a lot of training and it was very stressed throughout the whole program, but there's not much attention towards people's mental health and how they would act in certain areas or different issues that people might have with mental health issues. Seeing a lot more emphasis on that would have been nice... Maybe prolong paramedic education by a year to fit in extra courses and awareness. I think that would help. That would be like a bottom-up help, starting from the origin education as opposed to medics. With working medics, maybe just CMEs, I don't even know how else to get that across.

(Front-line paramedic: Interview 027, 2018)

8.5.2 Promising practices in mental health training

Along with suggestions and recommendations, some promising practices in paramedic education were identified. As noted above, comprehensive mental health training in the area of didactic content, practical scenarios as well as a practicum placement in a mental health or social

services setting were identified as positives aspects to paramedics' educational experience. These present as important components for potential refinement of paramedic student curricula.

Additionally, promising practices were identified in the form of continuing education for already working paramedics. An education superintendent from a paramedic service in Ontario indicated that they have been able to incorporate increasing amounts of education around mental health for their paramedics, as well as training around some of the more psychosocial areas of care. This particular service has a specific program in place for mental health calls, with training aligned to the program.

{Name of service in Ontario} has been very proactive with this. How to speak to people appropriately and what are the right things to say, what are the right things to ask and that kind of stuff. So we had people from our Crisis Intervention Services through our hospital, our local hospital here. So they came in and taught all of our paramedics, you know, about the correct thing to say to somebody when they're suicidal and the correct thing to say to people when they're having delusions and hallucinations and that kind of stuff; so it was really, really helpful but I feel like it is something that we need to keep up on, but yeah that's kind of what we did. And also as part of that we had a gerontologist come in and speak to us about older adults and aging and dementia and delirium, Alzheimer's disease that kind of stuff. That was the other side of it so I feel like now we're in a better place with it all. There wasn't a lot prior, I think we were still trying to get our feet under ourselves for the training stuff, you know, actually getting into a training department... so mental health has really taken a priority in the last few years, I'd say in the last five anyways, especially with the upswing of, you know, now we're seeing more and more kids.

(Manager in an Ontario paramedic service: Interview 038, 2018)

Additionally, a rural practicing paramedic spoke about a recent CME experience, when they heard from someone with lived experience who discussed interactions between paramedics and people with mental health needs. While this quote is lengthy, it so clearly lays out promising practices of potential benefit to paramedics, including gaining insights from those with lived experiences; understanding the reality of what someone's experience with paramedic services is when in distress; and receiving advice on effective and compassionate patient care.

We had a training day a few months ago that {name of service} put on, where they brought in someone that had been a patient of ours within the county. She was

someone that worked with the crisis centre at the hospital and was schizoaffective, she had schizoaffective. She spoke to us about her experience with the whole thing and her experience with paramedics and what we could be doing to help and things like that and like that I found incredibly helpful. Like I still find those calls very challenging, but it was very helpful to hear it from someone that had been through it to say like: “Don't come in and boss me around.” “Don't be silent in the back of the ambulance.” That was one of her biggest things which she didn't want. She hated the quiet ambulance rides, being strapped to a stretcher like Hannibal Lector. That, as training, I found probably the most helpful thing that we had. She said one of her other take-home points was don't downplay what they're feeling. Like “I understand that you see these things” or “I understand that you're feeling this” and “that's real and it's not made up or make believe or anything like that but, you know, I don't see those things” is basically what her take-home was...— because we see people at their worst, right? It's really easy to see a very unwell psychiatric patient and say “Oh my God, that person's a nut job. Moving on.” But when you can see them as a real person and say “Hey, these are the things that you do that affect me. Do this instead.” Like that is incredibly helpful.

The paramedic went on to describe other potential promising practices such as learning from mental health care practitioners, rather than trial and error by paramedics, and receiving specific training in crisis management options.

I would really wish that we would have something put on by, you know, a trained counsellor or a psychologist or something that just – We understand that pathology is behind them, but we don't understand how to manage them at all. Like we have no training on what to say to somebody with suicidal ideation. Like it's literally we go in and it's, you know, trial and error, is how I learn to manage it. Like, okay, going in and yelling at somebody, that doesn't help. So let's not do that anymore. But have somebody that has – because all of our training has come from paramedics and, you know, we're not a qualified bunch when it comes to mental health, which is unfortunate. I wish we could have some sort of training on somebody that knew what they were talking about would be super helpful. A little crisis management, a little bit of just knowing what to say, knowing the right things to say, knowing the wrong things to say would be super helpful.

(Front-line paramedic: Interview 031, 2018)

These promising practices such as receiving insights from those with lived experience, training from mental health practitioners, and learning further crisis management options warrant further consideration for application by paramedic services to extend knowledge and skillset in positively managing mental health related calls and importantly highlight the role of service users in informing future directions of paramedic practice.

Consistent with the variation in paramedic student training, there have been some paramedic services in which training around mental health has appeared as more of a priority. In the majority of services however, ongoing education and training in this area is often limited. It was consistently cited that sufficient timing for education and keeping paramedics up to date with evolving skillsets is a challenge and time limitations have prevented inclusion of areas such as mental health. The suggestions and promising practices of paramedics offer seemingly plausible areas for addressing mental health in paramedic education and training.

8.6 Discussion

Through interviews with paramedics, paramedic management, Base Hospital managers and physicians, and educators in college paramedic programs, experiences of training for mental health calls were described as minimal and generally lacking. Despite some variation in the extent and ways in which training is carried out in different colleges and services, paramedics consistently wished for some further or ongoing training. They identified concerns not only with a lack of training, but also challenges they felt existed with what other training could be provided. Many paramedics highlighted what they felt was an increasing volume of mental health-related calls, and as a result, a desire for an overhaul to what training is required, as well as to how expectations for paramedic work are presented during training.

In exploring the role of education and training for paramedics, a feminist political economy approach considers the training and skills of care providers, as well as the conditions in which they're carried out (Armstrong, 2013). This approach considers the limitations that training may present for both the care provided and care received (ibid). In the case of mental health calls and paramedicine, previous chapters have identified that the methods for providing care and skills of paramedics for mental health-related calls are variable and often limited. Exploring the training and education received, it is evident that limitations also exist. Ultimately, training around mental health-related calls both for paramedic students and

practicing paramedics is minimal. This section will first summarize some of the gaps and limitations in paramedic education and training, followed by a discussion of training in broader context including the value that is placed on certain types of training and work and the limitations to expanding training to improve care.

8.6.1 Gaps in training

Significant changes to the nature and scope of paramedic work as well as generally increased demands on paramedic services, have a direct relationship with the education provided for paramedic students (Edwards, 2011; Williams, 2012). At the completion of training, paramedics possess clinical knowledge and ability to apply the knowledge; however they lack confidence in doing so given limited exposure and experience (Thompson, 2015). At the stage of entry to practice, paramedics depend on support from colleagues, peers and preceptors (*ibid*). Training and application for mental health calls are more limited than medical or trauma. New and experienced paramedics indicated a need for further training. In this study, paramedics indicated that their care provision around mental health calls is often self-taught, and/or based on their personal or work experiences. Educators indicated that while paramedics typically have exposure to some of the more “stereotypical” or “basic” mental health calls in their training and practice scenarios, they have often gained less exposure and practice in managing the nuances and intricacies of complex mental health and psychosocial calls, as well identifying the range of psychosocial needs on a scene. The training priority on biomedical care provision and skillsets that are more easily measured and quantified, aligns to the acute care focus of the health care system, where medical or trauma skills are valued and emphasized in training (Williams, 2012). When working toward ensuring health equity and equitable care provision, such biomedical orientations provide challenges where other elements of care must also be prioritized. The concept of value placed on certain skillsets will be further discussed in Section 8.6.4.

With regard to in-class, didactic curriculum content, many paramedics and educators spoke of learning about the DSM categorizations of illness and disorder, but little else. Only one educator referred to teaching around the SDOH. Inclusion of SDOH content in curriculum has the potential to create awareness of the circumstances that create distress, potentially leading to calls to paramedic services. It may contribute to paramedics’ development of a critical lens on issues impacting individuals’ health and mental health, and better understanding the

circumstances of the patients they care for. A restructuring of medical curriculum to critically engage with the SDOH has been recommended (Sharma et al., 2018), and this seems applicable to paramedicine.

8.6.2 The role of experiential education and preceptors

Both paramedics and educators supported expansion of didactic, in-class learning around mental health by moving beyond an introduction to psychology or DSM classified disorders and providing content specific to what paramedics may encounter, as well as the ways in which this ought to be managed. They indicated a need for further skills and scenarios training in this area, as well as for an opportunity for practicum placement focusing on mental health and psychosocial care. In their discussion of learning contexts for paramedic students, Mausz and Tavares (2017) highlight that there is value in students learning not only in settings of eventual practice (ie: learning in context on the ambulance), but also learning in professionally ‘distant’ contexts (ie: a hospital clinical setting). Such ‘distant’ contexts such as other mental health services settings may prove useful as one piece in expanding paramedic education for mental health-related care provision, as was expressed by multiple educators and paramedics.

In addition, the role of preceptors in paramedic education around mental health calls is an important factor in mental health call education. Bowles (2009) states, “Instructors and preceptors serve as models for their students through their everyday language and behaviour” (Bowles, p.7). Instructors and preceptors are influential in paramedic learning, with the ability to shape the practice and behaviours of paramedics. The role of the preceptor in developing paramedic students’ practice on mental health calls has the potential to be substantial, given the experience-based learning of paramedics in the area of mental health calls.

8.6.3 Continuing medical education and the subjects of on-going training

CME for mental health calls, continues to be an area to which little or no time is devoted, with many competing priorities for updating paramedics’ clinical skillsets and knowledge. As noted by one Base Hospital physician, CME content often depends on current events, such as in the case of the opioid crisis. Receiving “current event” training for paramedics often leaves limited time for other training in the area of mental health. Both new as well as experienced paramedics identified mental health as less of a focus in their experiences of training

and learning, with biomedical and trauma focused training remaining at the forefront of much of their education both when they were a student and currently.

Beyond the relatively limited time devoted to training and education in this field at all levels of training, there are challenges about how best training can be carried out. Paramedics presented concerns, indicating how they felt more training would be beneficial, yet not knowing how training could be provided in a field with so many “grey areas.” Concerns were presented with what training will be most beneficial for paramedics given their limited time with patients and their limited background in fields such as psychology or even social work. Furthermore, challenges exist with instructors teaching the content, whether their background is specifically mental health, or paramedicine or a combination of the two.

8.6.4 Training in the broader context

The way that paramedics perceive their own competence is significantly associated with patient outcomes (Hörberg et al., 2017; Wihlborg et al., 2016). Improvement to paramedic education and training has the potential to improve the care provided by paramedics to individuals in distress as well as paramedic level of comfort and competence in managing these calls (McCann et al., 2018). Given the limited training in this area and the need for it identified at the level of front line paramedics, paramedic management, Base Hospitals and paramedic educators, training and education is an area requiring further attention. Necessary to consider however, are the way in which some types of training and work are prioritized over others.

First, how is ‘emotion work’ valued in paramedicine? A feminist political economy analysis of care work draws attention to the value placed on certain skills in the workplace, as well as the conditions in which the care work is carried out (Armstrong, 2013). This approach highlights that the necessary skills for care work are not solely made up of “readily observable capacities, job descriptions, or credentials,” (p.102). The area of social care, often considered “soft” rather than “hard” skills, is consistently less valued (ibid), and is less attended to in training and education. In the case of paramedicine, hard skills such as medication administration, physical assessments, trauma management and other care based in biomedical understandings of health, are of substantially greater focus than soft skills such as communication, and the relational work involved in providing care and support for individuals with mental health and psychosocial needs. These formal skills, outlined in education standards

and required for completion of exams and certification, do not necessarily include the only skills required by paramedics to practice successfully.

As previously discussed, the origins of paramedicine are based in medicine and the biomedical and Williams (2012) notes medicine to be a “scientific, rational and masculine approach,” (p.369), highlighting the ‘masculine’ origins of paramedicine. ‘Emergency work’ (McNamara, 2016) and typically male-dominated service work (Bishop, Cassell & Hoel, 2009) are ‘masculine’ components to paramedic work and paramedics are largely “expected to adhere to a strict traditional hegemonic masculinity” (p.371) in identity and behaviour in their work. Importantly however, paramedicine is a unique profession, in that it incorporates both ‘masculine’ and ‘feminine’ elements of work, namely through being both ‘emergency work’ as well as ‘care work’ (McNamara, 2016; Williams, 2012). McNamara (2012) states also, that paramedicine is relatively *less* gender segregated than many typically ‘masculine,’ or ‘feminine’ occupations. Despite being still primarily male-dominated - 66% male as of 2017 (MOHLTC, 2018), this is relatively less gender-dominated than other ‘masculine’ or ‘feminine’ professions such as firefighting or nursing.

While paramedicine has always had a ‘care work’ element to the profession, and as such, both ‘masculine’ and ‘feminine’ roles in the work, the ways in which different roles are valued varies. Williams (2012) notes that the dominant, ‘masculine’ approach of medicine “serves to subordinate and devalue emotion work” (p.369). McNamara (2016) describes paramedic calls that involve social work or counselling type roles to involve emotional risk-taking, something definitively ‘unmasculine,’ which may be a less than favourable undertaking, compromising the ‘masculine’ identity. Particularly, given the increase in ‘emotion-focused’ care work with mental health and psychosocial calls, this gender based analysis draws insights into some of the reasons that training has been limited on these calls, and these calls are not thought to be typical of paramedic work. While doubtless, factors such as misaligned expectations of the profession itself – in the mainstream, more associated with action, medical and trauma emergencies, and high-acuity calls, have implications for less appeal in these calls, the gendered origins of the work may well play a role. Using gendered work as a framework for understanding the lack of incorporation of mental health and psychosocial care training reveals how a more ‘feminine’ caring role is largely absent from paramedic training as it relates to mental health with its ill-defined practice.

The value placed on different types of work and different skill sets seems apparent here. Undoubtedly, the skills that need to be performed in life threatening, high acuity physical health emergencies must be practiced and be performed to the highest possible quality – interventions without which there would be immediate, life-threatening consequences. As such, these skills must be prioritized in paramedic students’ learning and in front line paramedics’ ongoing education. Despite this priority, the literature as well as my findings from interviewing and observing frontline paramedics and paramedic services work shows how mental health and psychosocially-related calls comprise a significant proportion of the work. Non-emerg calls, and calls where no medical, trauma or medical interventions are performed are significant in volume (Bigham et al., 2013). Given the frequent occurrence of these calls and the on-going implications for care and wellbeing of individuals (even if perhaps less obviously immediate and acute than the physical health emergencies), it seems that higher value is afforded to “hard skills” rather than the care work soft skills needed for mental health and psychosocial calls.

Emotional labour, a concept initially identified by Hochschild (1979; 1983) involves “the effort we invest in managing our own emotions and those of others, particularly the way individuals manage both the inner and outward feelings” (Riley & Weiss, 2015, p.7). It has most commonly been studied in the nursing field, as it has been thought to be “part of the image of nursing” (Mann, 2005, p.305), and traditionally something seen as “female work.” In the emotional labour literature, emotional dissonance is seen as the result of a worker’s genuine emotions not aligning with the ‘emotion display rules’ (Mann, 2005). In other words, there are certain emotional demands that exist for workers in their ability to navigate and manage their own and others’ emotions, and certain displays of emotion that are required or beneficial for the work, and these do not necessarily align with the genuine emotions of the worker. While the ability to not display genuine emotion may be positive for some workers in some circumstances, it is found to have some negative outcomes. Emotional (as well as cognitive) dissonance has been identified as a significant contributor to stress and burnout for professionals in the health field who perform such work on a regular basis (Riley & Weiss, 2015). The benefits of emotional labour for care recipients in health care is significant for patients who may be experiencing a range of emotions including pain, fear, anxiety or panic (Mann, 2005). Despite the critical role that emotional labour plays in many health settings, it continues to be poorly taught in many health care programmes (Mann, 2005). Emotion work falls into the category of

“soft skills,” which have traditionally been undervalued, consequently jobs which involve emotional labour have been commonly less well paid, and also, as noted above, involve limited training.

Studies of paramedics’ emotion work focus on engagement with patients and family when responding to emergencies, as well as work by the paramedic after that interaction such as strategies to manage the emotional demands of emotion work in paramedicine (Williams, 2012;2013). This literature indicates that while in fact “the majority of paramedic work involved dealing with non-urgent calls requiring the greatest emotional labour, training focused on technical skills and attention to emotional labour was rare” (Williams, 2012, p.369).” In paramedicine, emotion work and emotional management were talked about as being ‘learned on the job’ (Filstad, 2010). For paramedics who are exposed to a range of human emotions, including suffering, trauma and death, emotion work may be a critical component of the work, however there is a lack of attention to this type of work within the profession (Williams, 2012). While not limiting ‘mental health care’ to only ‘emotional labour’, it certainly comprises at least an element of emotion work and certainly applies to the concept of ‘psychosocial care’. More training has been identified, and it seems that skills related to perhaps more intensive or complex emotion work such as in the case of mental health calls, presents the same need.

The traditionally biomedical, medically dominated origins of paramedicine have largely shaped the content and priorities in paramedicine training. As policy shifts have occurred and changes to the mental health, health and social services systems have occurred with retrenchment of the welfare state and greater focus on acute rather than chronic or preventative care, the demands of paramedic work have evolved. As a result, paramedics must be appropriately prepared to manage calls outside of their traditional domain. While emotion work has historically been undervalued with limited training, placing value on emotion work as a skill, and with the goal of evidence-based practice informing paramedic training and practice, there is a need to evolve paramedic training to ensure most promising practices are in place for the management of these calls.

8.6.5 9-1-1 “care” training

As discussed in Chapter 5, changes have occurred for all emergency services in the care needs they are filling and challenges have been identified in the types of training received for this

care. Braedley (2010) discusses that as fire fighters took on more medical care work resulting from these neoliberal policy shifts, they gained interpersonal and communication skills, watched other fire fighters with trial and error, however they received no formal training for this work, and were not actually trained to provide such care. Likewise, the additional psychosocial and mental health-related care paramedics are providing fills in gaps in other parts of the health, mental health and social care systems, but training has not yet evolved to reflect these changes.

Police have also felt inadequately trained to deal with mental health calls (Franz & Borum, 2010) and presented concerns that they are not mental health workers (Cotton & Coleman, 2010). While some improvements have occurred for police management of individuals with mental health needs, inquests into police interactions with individuals with mental health concerns which have resulted in a fatality continue to find police have not received sufficient training (Cotton & Coleman, 2010). Coleman & Cotton (2010) identified that while Canadian police academies/colleges do include basic training for individuals with mental health needs, the follow-up training varies service to service and there has been no standardized curricula. Ultimately, it seems that despite the significantly increased role of emergency services in providing more mental health and psychosocial care, training in this area has lagged.

8.6.6 The limits of education and training

Tensions exist between the need for training and the reality that despite additional training the care that paramedics provide is carried out within particular working conditions and contexts. Previous chapters in this dissertation highlight how there are multiple areas that impact the care provided by paramedics beyond their training and education. As identified in the previous chapter, the mental health of paramedics, and the possibility of compassion fatigue and burnout may impact the quality of care they provide. Also, frustration with lack of on-scene resources, lack of alternate transport destinations than the ED, and limited resources for call management may impact paramedics themselves as well as the care they are able to provide. The importance of these working conditions for paramedics limit the extent to which additional training is able to improve responses to mental health related emergencies. Additionally, reactive responses by paramedics, even if well trained, do not prevent these calls, or address the factors that are leading to increased rates of distress. These conditions of work related to

staffing, resources and limited scopes of practice ultimately limit the care paramedics are able to provide and the extent to which training can address this issue.

Armstrong (2013), in her discussion of skills involved with care work, states that these skills as well as the care provided must be considered within the broader context and environment in which it is carried out.

The goal is to shift the focus away from the individual to the conditions and relations of work. Instead of concentrating on how we can change the workers, the issue becomes how can we change the workplace to ensure skills appropriate for treating {individuals} with dignity and respect are developed and employed.

(Armstrong, 2013, p.101)

8.7 Conclusion

Through interviews with paramedics, paramedic management, Base Hospital managers/physicians, and educators in college paramedic programs, I found that experiences of training for mental health calls was minimal and generally lacking. Despite some variation in the extent and ways in which training is carried out in different colleges and services, paramedics consistently wished for some further or ongoing training. They identified concerns not only with a lack of training, but also challenges they felt existed with what other training could be provided. Many paramedics highlighted what they felt was an increasing volume of mental health-related calls, and as a result, a desire for an overhaul to what training is required, as well as to how expectations for paramedic work are presented during training.

Training alone cannot change the conditions of work for paramedics, such as adequate staffing, sufficient resources, guidelines for care and the rates at which certain types of calls occur. Attention to training however is necessary to improve paramedic response to these calls as they occur, as well as paramedic comfort in managing these calls, potentially improving the circumstances for both patients and paramedics. A need for further training and a focus on mental health and psychosocial calls has been identified by front-line paramedics, educators, paramedic services and Base Hospital managers and physicians. Potentially promising practices for paramedic students and front-line paramedics include expanding the content of didactic learning in this area; providing further clinical experience specific to mental health and social needs; and increasing involvement from those with lived experiences and other mental health

services experts who may be able to further guide paramedic practice in this area. While limitations to training exist given the lack of standardized care and guidelines in this area, there is also the potential to develop more standardized guidelines and training.

The lower value associated with ‘softer’ skills such as communication, interpersonal and supportive skills required for managing mental health and psychosocial calls must be addressed with an understanding of the substantial implications for patient populations and the volume of these calls to paramedic services. While changes to some of the broader conditions impacting paramedic practice in this area may be limited, education is one domain in which care can be improved, with implications for individuals in distress as well as the paramedics providing care.

Chapter 9: Mental health projects and programming in paramedic services: Promising practices for future directions

9.0 Introduction

For most paramedic services the only option when responding to a mental health related call is for the paramedics on scene to provide care and then transport to the emergency department (ED). In contrast, a small number of paramedic services have taken steps to implement programs and interventions for mental health related calls. These programs have taken several forms: diversion programs that re-direct to destinations other than the ED such as mental health or other social services; team work between crisis intervention teams including mental health workers and police officers; and community paramedicine programs which provide follow-up to individuals who have received paramedic services related to mental health or substance use needs. Through these programs, paramedic services are aiming to expand the scope of care that paramedics are able to provide to individuals with mental health needs, connecting individuals in distress with more appropriate care and resources.

9.1 Pilot projects and programs

This chapter presents examples of programming for paramedics and mental health calls, including pilot projects and programs within Ontario. It compares across case study sub-units: a site with no mental health programming, a site with minimal programming, and a site with extensive programming. I present findings from my interviews and observations with paramedics and paramedic services management regarding programs in place within Ontario paramedic services (September 2017 – October 2018) which are evolving continually. This chapter is not a programmatic analysis of the mental-health related programs in paramedicine in Ontario, but rather it seeks to identify the areas in which programs have been established and the promising practices that exist in Ontario. Finally, I discuss the role and relevance of programs through paramedic services addressing mental health needs and the social determinants of mental health. I will present the benefits of implementing specific programming related to mental health calls within paramedic services, as well as the importance of understanding mental health in context, such as in the creation and implementation of such programs for comprehensively addressing the issue. While a SDOH framework highlights the need to address these calls

preventatively, in social and economic policy, here I will also discuss the significance of such programming for frontline work to improve the situation for those in distress and crisis.

9.1.1 Diversion programs

First, diversion programs are one solution to transporting individuals with mental health needs to the ED allowing paramedics to transport an individual to a destination other than the ED, ideally to better meet the needs of the patient. Diversion programs have existed for many years in certain areas of prehospital care such as trauma bypass, stroke bypass, or STEMI bypass (for myocardial infarctions). These allow paramedics to bypass the closest hospital in order to transport individuals to the most appropriate facility based on their assessments in the field (Bigham, 2013). In the case of mental health calls, this has been uncommon or non-existent until recently. Diverting to a location other than a hospital for mental health needs is relatively new and much less common.

Within Ontario, several paramedic services have begun to employ mental health diversion programs as well as for substance use or other psychosocial needs. Some are pilot projects and others are longer standing programs. These programs involve a protocol ensuring that the patient falls within certain normal vital signs limits; consent from the patient as to whether they want to go to the ED or the alternate facility; and some programs with stipulations around substance use (for example whether or the extent to which they have drugs or alcohol in their system). Different services divert to different receiving facilities, including shelter and community services, mental health facilities, as well as a separate entrance and space attached to the ED, specific for those with mental health needs. One paramedic described it in this way:

...diversion is kind of – well we realized that we're just – we were acting like a revolving door, we were just picking up patients with drug and alcohol or mental health problems and bringing them to the hospital. They may or may not be seen by Crisis or they may or may not be seen by anybody in Addictions or that kind of thing, and then they'd sober up or they just stayed there long enough that they calmed down or whatever, and sometimes they'd leave; or sometimes they would be assessed but then they would leave, and we knew that this wasn't... that they needed to be brought to the proper source.

(Manager in a paramedic service in Ontario: Interview 038, 2018)

In speaking of a diversion program, which enables paramedics to decide to transport individuals from the shelter system to other specific shelter or community services, one member of paramedic services management spoke of its benefits:

As long as they're not actively suicidal or aggressive, we can take them to this program where they get a care that's really targeted for them with a follow-up instead of being taken to the emergency department where it's, basically, a revolving door.

(Manager in a paramedic service in Ontario: Interview 035, 2018)

Front-line paramedics identified a range of benefits to their diversion program, including what they see as benefits for the recipients as well for paramedics themselves.

...it's fantastic. You give a similar report to what you would to the triage nurse, but the great thing is, is that there's only one patient in that room at a time, so the patient doesn't have to worry about anyone hearing, it's in a closed-off space with a closed door. No one can hear what you're saying. So from the patient's perspective, I'm sure that it's very reassuring to know that they're not in a hospital room with just curtains protecting them and the person next to them can hear what they're talking about. And for us it's great, because we don't have to wait and wait for the offload delay process with somebody who doesn't have an acute medical emergency. It's great, because we can just get back on the road and answer the next call.

(Front-line paramedic: Interview 030, 2018)

Paramedics working across different programs stated that they find a majority of the individuals they interact with to be receptive to their diversion program, and pleased to have an option other than the ED. Paramedics identified benefits such as the relative speed with which individuals are able to speak to someone trained specifically in mental health and in a supportive environment. Additionally, in one paramedic service where a diversion program was underway, paramedics spoke of the impending mental health program with real anticipation and enthusiasm at the positive impact it could make. One paramedic suggested she had been more engaged in thinking about mental health calls since the program was introduced, suggesting that the new program had stimulated her thinking around this type of call.

The paramedic services engaged with diversion programs identified certain challenges in establishing the programs, such as legislative barriers preventing transport to non-hospital destinations tied to issues with billing to hospital. Additional challenges for those connected to hospital facilities include reluctance from hospital staff to adjust to the new program and engage with the program as well as challenges with a lengthy protocol for frontline medics employing the program. Services described growing pains with their programs; however, they largely identified successes with paramedics' abilities to appropriately apply the protocols and to safely divert individuals to their programs, and to fewer transports of individuals with mental health concerns to the hospital EDs. They highlighted the benefit of decreasing the wait time to access care and for it to be provided in a setting other than the ED to minimize distress. They also importantly highlighted that from community settings and with community mental health services, individuals were more appropriately provided options for follow-up care, and found themselves in facilities that could assist them with addressing their mental health as well as a range of social needs such as food, housing, income and employment. The potential benefits to those receiving care as well as paramedics providing care were apparent from these discussions with paramedics.

9.1.2 Crisis response teams

Second, paramedics in Ontario noted a number of crisis response teams as resources in managing mental health related calls in the prehospital setting. Teams variously involved the pairing of police with social work, a mental health nurse, or a mental health worker, and occasionally one of the above with a paramedic. Crisis teams are often activated by paramedics on scene, who request the involvement of the crisis team. Sometimes crisis services are activated through dispatching prior to any paramedics arriving scene. Additionally, some services stated there was a crisis team they could phone, specifically mental health professionals, who with the recipient's consent could connect with them. The intent is for crisis teams to be able to come directly to the person in distress on the scene, where typically paramedics remain with the individual in distress until the team has arrived. The recipient of care may remain with the paramedic or can then be transported to a crisis centre.

While observing in one service with a mental health programme and access to a mobile crisis team, the manager described the interaction in this way:

Well, I know now that since we've put in place the Crisis Mobile Team and the pilot for the alternate care pathway the paramedics seem to be more willing to actively engage the individual on scene to offer these additional resources and alternate care pathways. And the feedback that I've received from the paramedics is that it's been absolutely positive, they just wish that they had ability to do this, you know, 24/7 and that those resources were available 24/7 to them. Because a lot of it could be managed, you know, in the comfort of the individuals' homes or being able to redirect them to a more appropriate, and safe, and warm and welcoming environment as opposed to an emerg department.

(Manager in a paramedic service in Ontario: Interview 032, 2018)

There is often only one team for a given region who might or might not be able to respond in time, creating limits on their capacity to intervene. Additionally, liability and logistical challenges exist when individuals will not remain in paramedics' care but remain with the crisis team. Paramedics identified circumstances in which the availability of crisis teams has made a real difference on calls, and has offered a strong and effective alternative to the care they otherwise would be able to provide. An additional challenge however remains the availability of crisis teams and also that there are a range of other mental health-related calls that paramedics respond to where they will not have crisis teams available, or crisis will not be appropriate support as it is not an acute mental health emergency but more of a chronic or ongoing issue. The structures and ways in which these teams are available and implemented vary service to service. Typically, other than one service currently piloting a project directly involving paramedics, crisis response teams are not based in paramedic services, but rather through police services or other community mental health services.

9.1.3 Community paramedicine

Thirdly, the most consistently mentioned pathway to address psychosocial concerns is the community referral program, often called Community Referral by Emergency Medical Services (CREMS). The 2006 origin of this program is through Toronto Paramedic Services in 2006 (Verma et al., 2018) and it has continued and expanded throughout Ontario. Some form of this

program existed in each of the services with which I conducted the study and seemed to be widely existent throughout the province. The program allows paramedics the option to do a follow up referral after a call, if the patient has unmet home care or other unmet needs. They could make a referral to the home care program, at that time the regional Community Care Access Centre (CCAC), (now referred to as Home and Community Care through the LHINS). The process involves the home care program following up and connecting with the patient to assess needs and offer to connect the individual with home or community services such as case management, nursing, physical therapy, occupational therapy or other personal support services (Verma et al., 2018). Paramedics may make these referrals as a part of their documentation at the completion of a call. This resource is available where and when the needs of the individual are not necessarily medical in nature, however the paramedic feels that there are unmet needs in their living circumstances, such as home care or community services as outlined above (Verma et al., 2018). While often these referrals are thought of for older adults, for many services, the referral may be made for a patient of any age.

Paramedic referrals right? Into social service agencies. So if we walk into a house and, if we know and it generally, somebody's over 65 and we know that they're not taking their meds regularly, they're not taking care of themselves, they can't bathe, they can't wash, they can't keep their house clean. There's a part on our ACR {Ambulance Call Report} that we can fill out and it kind of red flags them and they get sucked into some, into the Community Care Access program or it gets, it's supposed to spur community care access to ask, to kind of go into the home and say, is there something here we can do.

(Front-line paramedic: Interview 008, 2018)

One paramedic educator discussed the ways in which CREMS referrals have expanded paramedic assessment pertaining to psychosocial needs when this was not necessarily a part of paramedics' initial training, also involving greater awareness of the SDOH.

Yeah, I think those ones are where your CREMS referral became really good at getting people to identify even, I mean yeah I would say some determine help, but I would say more the living conditions, the ability of someone to care for themselves. I think that was really brought to the forefront with the CREMS referral system that, and again I go back to, not to keep going back to, but I go back to education there

because medics in the past didn't look for these things. When they brought the CREMS referral forward they started saying, hey, you should really be looking at: Does your patient have enough food? Do they take care of themselves? What's the upkeep of their home, and if they're not doing that, this is a high risk patient? This is somebody that should be referred into the system. I think it took some time but once they started doing that, that became part of paramedic practice. So I think when we look at those sides of things, I think medics are fairly in tune with them.

(Front-line paramedic and paramedic educator: Interview 036, 2018)

The educator further stated that some challenges with CREMS referrals occur, for example, at end of shift: paramedics observe particular psychosocial needs on calls, but when they are particularly pressed for time with their other paperwork, referrals likely decrease. Additionally, the specific services available as a result of these referrals vary from region to region; however, some paramedic services indicated that counselling or other mental health supports are available. A number of paramedics indicated their belief that mental health specific supports were not necessarily available but identified how it would be a benefit if they were.

So that initiative started, four-ish years ago, where we started making CCAC referrals. We'd go in to mostly elderly patients and we could identify sort of a need for some extra homecare services or stuff like that. Services that the patients themselves didn't even know existed and so we were able to send referrals through CCAC to get them the help in the home that they needed. And I really feel, personally, like that has decreased some of the calls that we're getting out to these people. So if there were services sort of like that for mental health related calls for instance, you know, maybe that would decrease the amount of mental health calls that we go out to, because they would have sort of direct access to services in the community without having to try to navigate them through the hospital, which doesn't always work.

(Front-line paramedic: Interview 029, 2018)

These descriptions of community paramedic services identify how some gaps in social care and mental health services are being identified and potentially managed by paramedic services.

9.1.3 (a) Other community paramedicine initiatives

Fourth, community paramedicine is a rapidly expanding domain of paramedicine. Many of the projects and programs being initiated involve a more psychosocially focused follow-up for users of paramedic services. Other mental health-related initiatives in community paramedicine include follow-up by paramedic services and other mental health workers following substance use related calls, as well as referral programs for those with repeat police and ambulance interactions related to underlying mental health or substance use issues as well as income and housing. While many of these programs relate more specifically to chronic disease or home care, mental health and substance use related needs have come to the forefront, even during the time of the field work (September 2017-October 2018), particularly with the increase in the opioid crisis.

Figure 9.1 Possible pathways for mental health care in the paramedic prehospital setting

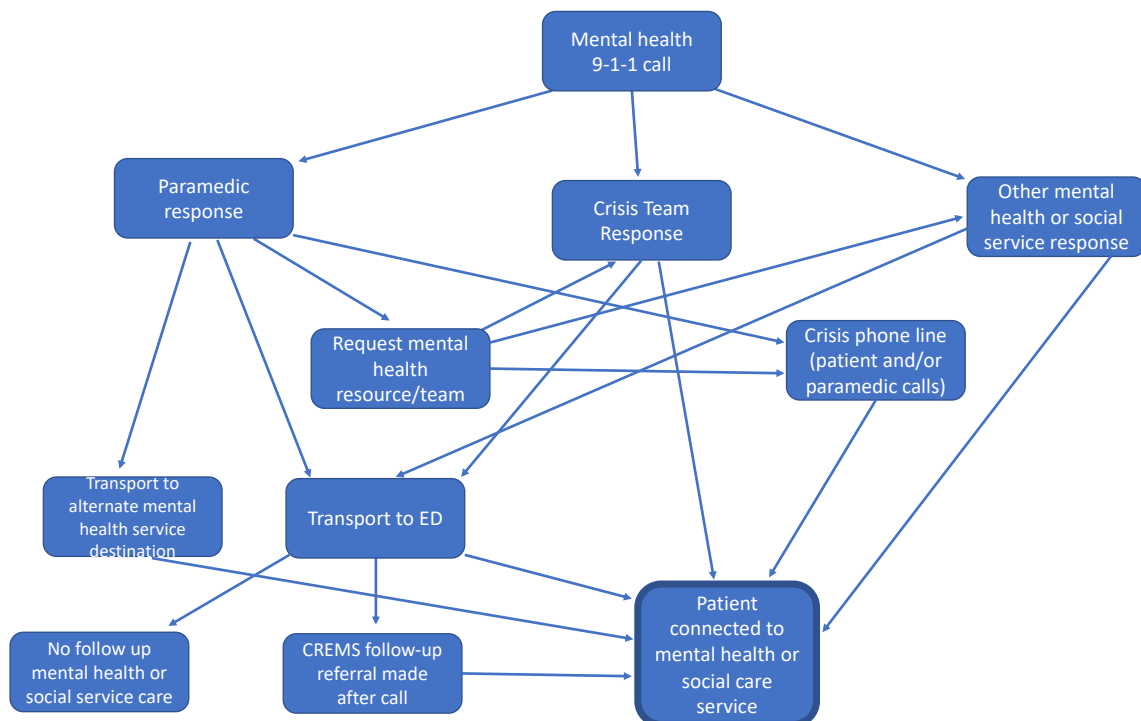


Figure 9.1 illustrates the possible program or resource pathways to mental health care in the prehospital, paramedic services setting. Many of these possibilities do not exist in most paramedic services in Ontario, however some exist in a variety of formats as discussed above. There is no formal listing of paramedic mental health-related programs in Ontario. In contrast, the community referral programs were consistent amongst most if not all services across Ontario,

while the crisis programs were variable and not available in all regions, particularly those located in rural or remote geographies. In my review of the academic and grey literatures, combined with findings from interviews with paramedic services, only a small handful of services have currently established diversion programs or pilot projects related to mental health needs across the 59 land ambulance services in the province.

9.2 Discussion

There is little study of the effectiveness of expanding the scope of paramedic practice with additional competencies to address needs, that are unmet by traditional emergency paramedical response (Bigham, Kennedy, Drennan & Morrison, 2013). In recent years, paramedic services have been working to address the disparity in response times for life threatening emergencies as well as meet the needs of individuals requesting assistance from paramedic services (Snooks, Dale, Hartley-Sharpe, Halter, 2004). Services have been reluctant to make changes and implement programs for which sufficient research and evidence supporting change are lacking (ibid). Along with working to most appropriately meet the needs of individuals requesting assistance from paramedic services, focus has also increasingly been on addressing overcrowding in emergency departments (ED), and for paramedic services to be part of the solution (Bismah, Prpic, Michaud & Sykes, 2017). Findings from the UK, Canada and US estimate 30-50% of all transports by ambulance are ‘inappropriate,’ with as many as 50% of individuals transported, discharged from hospital ED without significant treatment or referral (Bigham et al., 2013). These findings indicate that there is likely a need to connect individuals with more appropriate services that will address the needs that drive them to seek assistance from paramedic services in the first place.

As with paramedicine overall, the extant literature pertaining to specific projects and programs in paramedicine – particularly for individuals with mental health concerns -- is extremely limited both in Canada and internationally. Shaban (2006), working from the Australian context, has assessed the literature pertaining to paramedics’ clinical judgment and decision making on mental health related calls and also identified a need for increased mental health assessment skills and greater capacity to collaboratively provide mental health care in the ED. Programs and options for paramedic care to address mental health and substance use

concerns is largely news media and non-academic grey literature and focused on service-specific programming (CTV News London, 2015; Ottawa Citizen, 2007; Porter 2012; Sollows, 2015; Vandonk, 2014; Ottawa Citizen, 2007). A range of these programs exist in some paramedic services in Ontario: diversion programs, crisis intervention teams, and community paramedicine.

This chapter identifies programs and initiatives in place within some paramedic services in Ontario, addressing mental health and psychosocial calls in the prehospital setting. These services range from programs supporting response to acute mental health crises such as diversion programs and crisis teams as well as elements involving follow-up and connection to additional service and resources. Additionally, there are preventative elements to the programs, supporting individuals identified as having particular psychosocial, mental health or substance use needs, and preventing further, repeat calls to paramedic services. These various programs represent promising practices designed to address mental health related calls in the prehospital setting and to improve the conditions of care for those in distress. Additionally, there is a question of how best to balance our focus on promising practices at the level of paramedic services for managing mental health calls, as well as the need to draw attention to prevention of crisis at larger public policy levels and a focus on the social, political and economic determinants of mental health? This section discusses the role and relevance of mental health-related programs and interventions through paramedic services in comprehensively addressing mental health needs and the social determinants of mental health.

9.2.1 Tensions between programmatic and structural intervention

Feminist political economy analysis draws our attention to power dynamics and structural limitations, namely the tensions between encouraging and implementing promising practices for mental health calls in paramedicine, and the need to ensure appropriate attention remains at the public policy level, so as to prevent individuals from arriving at such a point of distress. When analyzing these tensions, it is necessary to consider the tensions between structure and agency. There is the agency of paramedic services working to address these calls at the level of paramedic services, within the structural constraints of the health system, particularly the alignment between the prehospital and community care sectors. Paramedic services are working across these sectors to: ensure available resources for urgent, life threatening health emergencies; ensure appropriate supports and resources for those with non-medical emergencies and concerns;

and find programs and interventions that represent an appropriate response to the rise in mental health and psychosocial call volume to paramedic services. At the level of paramedic services, prevention is geared towards those with whom paramedic services have interacted – so as to prevent further calls from arising, and to address overwhelming call volume. Engagement with such programs may be both appropriate and necessary for ensuring that appropriate and high quality care is being provided by paramedic services for individuals with mental health needs and the obligations of paramedic services are being met.

Such programs draw attention to the influence of neoliberal policy making and governance and the implications for the ways in which care is provided. The neoliberal approach focusing on acute care interventions (Braedley, 2010) rather than prevention, perpetuates the push for interventions or programs for mental health calls at the paramedic services level, responding to crisis after the fact, rather than preventatively through other domains of social and economic support impacting the social determinants. As care has increasingly shifted into community settings, it has resulted in care provision in increasingly fragmented, less-visible community settings shaped by informalization and privatization of care (Milligan & Wiles, 2010). While not negating the benefit of interventions and programs, such programs exist as yet another element of fragmented community mental health care, while at the same time being put in place to address needs in an already fragmented system.

Health geographers highlight the role of place in care, stressing that “place matters” with regard to health and health care (Kearns & Moon, 2002, p.610). Place matters in who provides and receives care, and this experience is shaped by socio-political contexts (Milligan & Wiles, 2010). In their discussion of “good” versus “bad” care, Milligan and Power (2009) state:

Good care can, perhaps, best be defined as the provision of the “appropriate” physical, social, and emotional supports to meet the [self-defined] needs of the person requiring help in order to maintain as much independence as possible in their everyday lives. Good care should be delivered within an environment that is most suitable to the care-recipient’s specific needs, but should also take account of the impact on care-givers. It also needs to be delivered within a wider context of a caring and care-ful society free from gender, age, cultural or other forms of discrimination.

(Milligan & Power, 2009, p.569)

This raises questions about the most ideal forms of care provision, both in location (ie: hospital, paramedic services or other community mental health supports), and the ways in which care is understood and provided – whether through a cohesive mental health system, or through various community programs challenged by a lack of mental health system cohesion and integration. Furthermore, questions must be raised about areas of prevention – working to address the social determinants, to prevent arriving at a point of distress or crisis, requiring such interventions and programs through paramedic services.

An additional challenge to the unique programming in the paramedic services setting is the regional variation in accessibility. For instance, many regions and paramedic services have no mental health-specific programming at all, beyond basic community referrals. Accompanying this lack of universality of programs between paramedic services are inequities in access to mental health supports. This inequity creates space for the expansion of such programs to other services, and further highlights the inequities in care access for certain communities, particularly as care has shifted from the state to communities. This shift has the potential to be particularly relevant in rural and remote communities where services are often limited, and even through paramedic services, individuals may have extensive transport times and transfers between facilities before receiving any mental health support.

When speaking to paramedic services engaged in the issue of mental health calls, their interest and efforts are largely directed at such programs and interventions and a focus on what can reduce call volume. Understandably, these programs appear to have the most rapid implications for managing call volume, as well as ensuring that more appropriate care is available for those in mental health or psychosocial crises. The interest and investment of paramedic services presents benefits to paramedic services providing care as well as those receiving care in the community. The investment of the paramedic services currently engaged in such programming efforts offer tangible benefits and improvements to the current level of care and management of mental health call volume, and offer promising practices to other paramedic services seeking to better address this issue. At other public policy levels however, there is a need to focus more broadly on prevention, and address the social determinants of mental health that may help prevent people from arriving at a point of distress, addressing issues of income, employment, housing, safe neighbourhoods, experiences of discrimination and so on.

9.2.2. The SDOH and public policy

A SDOH perspective highlights the importance of drawing attention to the social, political and economic issues leading to distress and calls to paramedic services. A SDOH perspective highlights the need to focus at the level of prevention of distress through policy beyond the prehospital and mental health care systems so as to address broader inequities. Furthermore, with a political economy framework, there is a need to consider how neoliberal policies shift responsibility for care from the state to the community and the implications leading to distress with implications for those in need of support (Navarro, 2007; Teghtsoonian, 2009). Additionally, drawing attention to interventions and the ‘inappropriateness’ of mental health calls to paramedic services runs the risk of drawing attention away from these structural inequities impacting mental health (Ford-Jones & Chaufan, 2017, Wiktorowicz, 2005). There is a need for policy to engage with the prehospital health and mental health care systems, yet also reach beyond these systems to address broader structures contributing to mental health inequities (Ford-Jones & Chaufan, 2017; Fisher & Baum, 2010). These policy areas include areas that impact the social determinants such as housing, income, employment and working conditions (Allen et al., 2014; Fisher & Baum), along with social relations such as racism, sexism, homophobia and other forms of discrimination (Fernando, 2010; Mills, 2015) that have significant implications for individuals’ mental and physical health and overall wellbeing.

In their study of barriers to addressing the SDOH through public health in Ontario, Brassolotto, Raphael & Baldeo (2014) discuss the structural challenges of public health as an institution with a largely individualized discourse on health. They discern how public health professionals are typically trained in clinical areas with an individualized understanding of health, something that is not aligned with the SDOH which focus on meso and macro level contexts about that which impacts health and wellbeing. Micro-level, individualized understandings of health are the foundation of biomedical discourse around health and health care. Brassolotto et al., (2014) challenge “approaches to health – and governance – that focus on ‘objective,’ uncritical, and noncontextualized data” (p.332) noting that a shift in epistemology in the politics of public health is required. They discuss that public health is necessarily political in that it is funded by municipal and provincial funds and its determinants are amenable to political interventions (Bambra, Fox & Scott-Samuel, 2005). The structural role of medical dominance in understandings of mental health, including such individualized discourse has substantial

implications for the ways in which we address mental health such as through addressing social, economic and other contextual factors impacting mental health, versus addressing mental health as simply physiological, to be managed by physicians and with medication. In order to comprehensively address mental health, we must work to shift the ideological barriers which have shaped such discourse and intervention thus far because addressing only psychological issues rather than political-economic forces and structures fails to address inequalities, poverty and systemic forms of discrimination that create distress and allow such conditions to worsen (Mills, 2015).

9.2.3 A role for paramedic services in addressing mental health inequities

The unique role of paramedics, interacting with patients in their own working and living conditions provides a distinct means of looking at and engaging with mental health inequities. A lens into paramedic services as a resource for acute psychosocial and mental health needs offers insights into areas requiring prevention and work needing to be done at the public policy level. Programs and interventions that work to address the social determinants of health (and presumably mental health) can significantly improve health (and presumably mental health) (Williams, Costa, Odunlami, & Mohammed, 2008). Many of the programs being implemented by paramedic services work to address some of the SDOH through connecting individuals to support and resources in the domain of food, housing, employment and other determinants of health. Unfortunately, at this time, these programs and the extent to which paramedic services are addressing the social determinants of health remain extremely limited.

The constraints of paramedic services in call management include: the need to respond to any call, mental health-related or otherwise; the substantial time and resources paramedic services put toward a high call volume of mental health and psychosocial needs; and the commitment to delivery of evidence-based, high quality care in all domains of paramedicine. Considering these constraints it seems there is an appropriate place for paramedic services to be working to address their management of mental health related calls and implement resources and programs improving the conditions of care for those in distress. Additionally, this unique lens from paramedic services aids in informing the need for prevention and work at public policy levels to prevent individuals arriving at a point of distress and crisis.

9.3 Conclusion

This chapter outlines some of the programs and interventions being piloted and implemented by paramedic services in Ontario to address mental health and psychosocial needs encountered in the prehospital setting. These programs include diversion programs offering care options beyond the local ED; crisis response teams; and community paramedicine initiatives such as referrals to services and follow-up to crisis calls. This range of programs includes initiatives that have increased attention to mental health and psychosocial needs in the prehospital setting, aiming to offer more appropriate and supportive care for those in distress, and bringing attention and implementing promising practices to a previously under-addressed area of paramedicine. While many programs are in their infancy, still warranting research and evidence-based practices, many of these programs offer benefits to paramedics providing care in the prehospital setting through more appropriate options for care or referral, critically, to individuals receiving care. Such programs and interventions expand options beyond the medical setting for care in the ED, and potentially improve follow-up to crisis and prevention of future crises.

Despite these programs tensions continue to exist in the prevention and programming efforts of paramedic services working to address mental health and psychosocial calls, and there is a need to focus on social and economic policies levels to prevent crises. Reframing mental health beyond an individualized, biomedical discourse and action to the determinants of mental health will help to improve the working and living conditions conducive to good mental health and wellbeing. These efforts recognize distress as often a very reasonable response to immensely challenging and problematic living and working conditions. The efforts of paramedic services implementing such programs and interventions offer improvements to care provision, as well as address the concerns of paramedic services in resource availability for responding to a high call volume and working to decrease ED overcrowding. These programs improve care and address inequities in crisis and mental health supports by directing individuals to supports and services through which they can receive more appropriate mental health support and potentially comprehensive resources and services aimed at improving other determinants of mental health such as housing and employment. Importantly however, policy must engage beyond the prehospital, health care and mental health care systems to address the SDOH impacting crisis and calls to paramedic services. The social determinants of health and mental health as seen by

paramedic services, as well as opportunities for paramedic engagement in addressing these determinants of mental health will be discussed in the following, concluding chapter.

Chapter 10: Conclusions – Beyond medical care: Paramedicine and the social determinants of health

“I didn’t know you could live 15 years longer if you live on the right side of town.”

(Paramedic in an urban paramedic service - Field Notes, 2017)

10.0 Introduction

This dissertation is a case study of mental health and psychosocial paramedicine care work in Ontario. I explored this topic using both a feminist political economy approach and a SDOH framework, drawing attention to the conditions or determinants (such as living and working conditions) and contexts (such as the neoliberal context) in which mental health and psychosocial distress and calls to paramedic services arise, and in which care is provided and received. This dissertation contributes to our knowledge about the current state of paramedic education, training and practice in this area; and specific programming for mental health and psychosocial care within paramedic services. In addition, it draws specific insights from three paramedic services: rural, rural-suburban, primarily urban and I highlight the relevance of geography and place including variable resource access, and different working conditions.

A key finding was that community size affects access to mental health supports and resources both in the community and available via paramedic services. This variable access requires consideration in developing solutions to emergency mental health needs and practices in paramedic services. Additionally, each of the services had engaged with the issue of mental health and psychosocial calls to varying extents. One site had extensive engagement and had initiated programming to address mental health calls. The second site had essentially no engagement with mental health specific supports or programming. The third had some minimal engagement with supports available in the community. These differences, as well as interviews with other paramedic service management in Ontario who were engaged with programming around mental health and psychosocial needs, aided in informing Chapter 9 - promising practices for paramedic services, as well as highlighting the reality that the majority of paramedic services have no current programming specific to mental health and psychosocial care.

The services included in the study provided interesting insights into variations among paramedic services through urban and rural care contexts and access to resources; however, in

combination with interviews from across Ontario, the front line experiences contributed to the central finding that mental health and psychosocial care are underexplored and under-addressed areas in paramedicine education, training and in practice across all regions in the prehospital care setting. Furthermore, consistent across regions is how much of the current narrative in this area is based in discussions of safety and violence, with little emphasis on care and support provided for individuals with mental health needs. Finally, while there may be a variable volume of calls from region to region, wherever challenging living and working circumstances exist in a region, paramedic services will be called.

This chapter presents the consequences of overlooking the SDOH, contributions to mental health discourse, mental health equity, feminist political economy as well as contributions and recommendations to paramedicine. Finally, I present recommendations for further research in this area.

10.1 Consequences of overlooking the SDOH

There is substantial evidence for the SDOH – the broad range of social, political and economic circumstances, which impact individuals’ physical and mental health and wellbeing. (Allen et al., 2014; Compton & Shim, 2015; Engel, 1977; Fisher & Baum, 2010). Failing to take these determinants into account or indeed minimizing their impact in understanding mental health and rising mental health crises has substantial consequences, and will continue to if they remain overlooked. These consequences discussed in the following subsections include, but are not limited to, medicalization of mental health, missing efforts at prevention, and misplaced blame for use of ED and paramedic services by those in distress.

10.1.1 Medicalization and medication

As discussed in the introduction and throughout the dissertation, a biomedical approach to mental health means that distress is medicalized, placing the problem at the level of an individual with inherent neurobiological ‘illness’ or ‘disease’ (Crawford, 1980; Kinderman, 2017; Mills, 2015; Zola, 1972). Medicalized understandings of mental health lead to medicalized solutions for managing distress, and focus at the individual level frequently involves the use of psycho-pharmaceuticals. While not negating some potential benefits of medication in addressing mental health in certain circumstances and certain individuals, there is significant

concern for over-prescription of many drugs, with little or no mental health support of any other kind. The role of the pharmaceutical industry with financial interests in perpetuating an understanding of mental illness as biological and in need of pharmaceutical intervention has presented as a significant and increasing concern (Davies, 2017; Lexchin, 2012; Rose, 2003; Whitaker, 2010). As noted by one paramedic interviewed, prescription medication is frequently the central ‘treatment’ for many individuals in distress without other supports and changes to other circumstances that may be impacting their mental health (Interview 003, 2017). When mental health issues are viewed as problems originating from biology or at least from an individual, solutions are then aimed solely at this level. Ultimately, there is a lack of evidence about the effectiveness of long term psycho-pharmaceutical use for a wide array of mental health conditions (Kinderman, 2017; Whitaker, 2010) and undoubtedly, this sort of ‘treatment’ alone, does not address determinants such as living circumstances that create distress. For instance, it is without question that prescribing medication for anxiety will not address the daily reality of living in precarious housing, with lack of employment and income, with bedbugs and with experiences of systemic discrimination.

10.1.2 Missing the mark on prevention

Lack of attention to the SDOH leaves a gap in working toward the prevention of distress. A biomedical approach to mental health directs thinking around prevention toward ‘illness’ prevention and toward research into genetics (Bracken & Thomas, 2012; Kinderman, 2017; Rose, 2003). A psychology-based approach, offers methods of addressing faulty ways of thinking through methods such as cognitive behavioural therapy (Teghtsoonian, 2009), which while undoubtedly presenting benefits to individuals working to manage their distress (Kinderman, 2017), does not focus on addressing or preventing the broader circumstances creating distress. It is necessary to acknowledge the limitations to the scope of practice of physicians and therapists working in clinical settings to address more structural determinants of mental health such as living and working conditions. Such approaches however miss the mark on addressing the circumstances and experiences that lead many people to experience very understandable and reasonable distress. A SDOH approach to understanding mental health highlights both the circumstances and daily lived experiences that lead to very real distress

experienced by individuals. This approach identifies how the areas for prevention are at the public policy levels by addressing social, political and economic determinants of mental health.

10.1.3 Misplacing blame on patients for ED and paramedic services use

When we overlook the social determinants, and the great many factors that are out of people's control, which create distress and lead people to a point of crisis, it often construes mental health issues as an individual 'problem.' It construes it as a 'problem' of patients misusing and abusing the prehospital and ED systems (Ford-Jones & Chaufan, 2017). This places blame at the individual level and misplaces focus as to what will help prevent and manage this issue. This perception of 'misuse', 'overuse' or even 'abuse' (Cuddeback et al., 2010; DeJean et al., 2016; Larkin et al., 2006; Porter, 2012; Prener & Lincoln, 2015) has negative implications for care provision by paramedics and ED staff, further fuelling frustration by overtaxed emergency health care providers, and drawing attention away from the factors people cannot change, which are significantly contributing to their distress and need for emergency support. Furthermore, it conceals the other gaps in the social and mental health care systems that drive individuals to emergency service use.

10.2 Contributions to mental health discourse

In this dissertation, I argue that to explore crisis resulting in 'mental health calls,' we must consider how we define mental health and what determinants, conditions, contexts, and relations improve or worsen it. This dissertation focuses on the SDOH, exploring the determinants of physical and mental health and the impact of these determinants in creating very real distress for individuals. It explores paramedics' discussion of what they see as factors affecting mental health on calls, in ways that few other care providers have the opportunity to see. I discuss how despite little or no formal training in the SDOH, paramedics refer extensively to these determinants as factors driving psychosocial and mental health distress and crises on the calls they attend. In Chapter 4, I present the contexts of calls to paramedic services and which determinants of mental health paramedics identify as distressing for patients. I present examples - - drawn both from paramedics' narrative accounts and from observations with various crews - - of factors perceived to create distress. Most paramedics seldom refer to biological disease and illness or problems at the individual level, but primarily identify distress as a result of adverse

and often exceptionally challenging circumstances, such as inadequate housing, lack of income, un/underemployment, inadequate food, social isolation and racism. There is, I argue, relevance of these findings for working toward prevention in mental health, addressing the factors leading to distress and crisis. While evidence for the SDOH have existed for well over a century (Waitzkin, 1981), it seems that further work is required in understanding and taking action on the determinants of physical and mental health.

This perspective of paramedics who are attentive to the SDOH supports current SDOH and critical mental health literature, and contributes to further understanding mental health with a contextualized lens. As Tavares et al., (2016) describes, one piece of the role of paramedics is being a “Health and Social Advocate.” While this role may refer directly to patient care on a call, or follow-up for a particular patient’s needs, this concept has the potential to apply to health and social policy systems as well as to issues of social justice. As the role and scope of paramedics expands and shifts in care provision, there is a need for paramedics to use their relatively privileged position to advocate for the circumstances that they are in the unique position of being able to see, that create distress and lead to crisis.

10.3 Contributions to mental health equity

While applicable to the area of mental health care in paramedicine, this research contributes to mental health scholarship with relevance to mental health care services and mental health policy. This SDOH-focused framing of mental health-related calls contributes to a broader understanding of mental health and attendant areas for prevention of distress. The findings support an understanding of mental health equity that accounts for not only access to mental health services, but also towards understanding that distress arises from very real, lived experiences, as well as to working toward greater equity, which requires addressing the social, political and economic determinants of mental health.

Equity in mental health is not simply defined by access to psychiatric services and access to psychopharmaceuticals. Equity in mental health includes access to social supports and programming that support healthy living and working conditions; daily living experiences free from discrimination based on race/ethnicity, gender, sexuality and ability; and access to mental health supports and services that acknowledge the significance of lived experiences, histories of trauma and limit the pathologizing of distress. As such, mental health equity must engage not

only mental health policy but other social policy areas, such as issues of inadequate income, un/underemployment, lack of safe and affordable housing, food insecurity, poor working conditions, social isolation and address structural issues of systemic racism, ethnocentrism, sexism, heterosexism, ableism and other forms of xenophobia which create profound stress and negatively impact mental health.

10.4 Contributions to Feminist Political Economy

Feminist political economy has been applied to the area of health and care, but less frequently mental health care (Haley, 2017). This dissertation contributes to feminist political economy scholarship in the area of mental health, and extends feminist political economy analyses by incorporating a SDOH approach as a means for understanding mental health, distress and mental health care. With a feminist political economy framework, this dissertation applied the concept of social reproduction and social provisioning to understand mental health care (Haley, 2017) as the daily maintenance of adequate social supports and necessary determinants of mental health required for successful social reproduction for mentally healthy and well individuals and communities. Importantly it also focused on who provides and receives care.

This study extends feminist political economy analyses to the field of paramedicine, mental health and psychosocial calls. By applying feminist political economy to this new content area, this work offers original insights into this area of prehospital care including the working and caring conditions in paramedicine, the importance of social care for mental health and wellbeing, and the role of the state in social provisioning. This study has highlighted the role of social care as a component of mental health care required both for the maintenance of good mental health and to support those already in distress, and highlighted the impact of neoliberalism in shifting responsibility for this care onto communities, families and individuals. Feminist political economy has aided in reframing issues of mental health calls in paramedicine from a quantitative, individual issue of “misuse” of emergency services, to one which accounts for the contexts creating distress as well as existing constraints for work and care. These contexts include the relevance of determinants of health, social care systems, physical and mental health care systems, as well as prehospital systems in understanding the context of these calls. This study confirms the feminist political economy assertion that the relationship between care providers and care recipients is central to understanding how care is received, and that the

working conditions of care providers have direct implications for care recipients, often limiting the care provided.

10.5 Contributions and recommendations to paramedicine

Building on the extant literature in the field of mental health and psychosocial paramedicine care work, the other main findings in this research are that training, education and practice guidelines related to mental health in Ontario are extremely limited. There has been little attention to this type of care work in paramedicine, consistent with the biomedical origins of the field. Findings from this study support enhanced training and education for paramedics, specific mental health related programming for paramedic services, as well as the importance of working conditions for both care providers and care recipients.

Front-line paramedics, paramedic management, paramedic educators and Base Hospital physicians/directors in this study indicated that training and education for paramedics is limited and further training and education would likely be beneficial. Current promising practices in this area of education include practicum placements for paramedic students in mental health and/or social services settings and for continuing education, and incorporating service user perspectives to provide insights to paramedics providing care for this population. Further education in this area for paramedic students as well as ongoing training for paramedics is warranted. Comprehensive content and delivery of such training will require collaboration between paramedicine and mental health service providers – bringing mental health expertise, and aligning learning goals with the realities of the paramedic services environment.

Specific programming in place to address mental health and psychosocial calls in paramedicine work include diversion programs that shift people away from ED when appropriate, crisis response teams, and community paramedicine follow-up initiatives. While this dissertation was not a programmatic analysis of these programs in paramedic services, positive feedback from paramedics was received regarding these programs as resources for people needing mental health and psychosocial support. Importantly, while programming that does not directly incorporate paramedics as a part of the team present benefits, paramedics still attend to calls where such resources are not necessarily available, indicating the need for either an expansion of paramedic training in this area or also paramedicine-specific programming or resources. Additionally, programs that offer services beyond immediate, acute, crisis

management, to address SDOH such as housing, employment, and social isolation seem to offer positive solutions to more comprehensively address mental health needs and potentially prevent future calls for paramedic services.

Finally, the importance of working conditions in paramedic services for both paramedics and patients is significant. Paramedic services vary from region to region, as do their structures and funding. Paramedics identified challenging working conditions regarding top-down management, inadequate staffing, not receiving breaks as needed and burnout. Specific to mental health calls, paramedics described limited guidelines and standards for providing mental health care, lack of resources on scene, and transport destinations for mental health and psychosocial needs limited to the ED. The current paramedic practice guidelines require reassessment and potentially collaboration with mental health workers to guide and support paramedics in this type of work and ensure that patients with mental health needs are receiving the most appropriate care possible. While safety and violence are critical considerations for paramedics providing any care, these guidelines need to move beyond a central focus on safety, to also incorporate de-escalation and other supportive care for patients who are not necessarily violent at all. Any changes to programming, training, guidelines and standards must also take geography into account, with high regard to the specific needs and realities of rural and remote communities.

The mental health challenges experienced by paramedics is one substantial piece of paramedic working conditions. The current climate of increased attention on the mental health needs of paramedics themselves presents an important lens on mental health calls for patients. Paramedics often referred to their own experiences, whether personally or with family or friends, in their ability to understand mental health calls as well as provide patient and compassionate care on these calls. The mental health of paramedics themselves is an important piece of the context and working conditions of paramedics providing care in this field, and while requiring continued attention, may also present a gateway to interest and discussion around care for their patients with mental health and psychosocial needs.

10.6 Recommendations for further research

This study has indicated multiple valuable areas for further research related to mental health care in paramedicine. First and foremost, research involving service user perspectives on

interactions with paramedic services is necessary. In particular, critical mental health emphasizes the need for service users to be incorporated into systems change and support that will be of appropriate benefit to service users themselves. While challenges exist with gaining service user perspectives at the time of interaction with paramedic services while potentially experiencing crisis, other opportunities to engage with individuals with mental health needs about their interactions with paramedic services must be sought.

While this study addresses challenges with transporting individuals to EDs and the transitions in care, it arose frequently that the ED is often a problematic site of care for individuals with mental health needs, a sentiment that paramedics' understood to be echoed by much ED staff. Other than the input of Base Hospital physicians, ED staff specifically was not interviewed for this study. Further qualitative research involving ED staff would be important to work toward further understanding and addressing care in that domain, and also to move beyond quantitative studies of rates of ED use for individuals with mental health needs.

Programmatic analyses could also be of benefit, exploring mental health-related programming in place in paramedic services. Importantly, this would require a contextualized understanding of where some programs might be better suited to some settings and community needs. I found little research specific to rural paramedic services or to rural mental health care in paramedicine. Further research into the mental health and psychosocial needs of rural compared with urban communities and paramedic services would be of benefit. Interprovincial research in the area of mental health and psychosocial care in paramedicine could also offer a means of surveying current practices in this area and better informing most promising practices.

10.7 Conclusion

In conclusion, I argue that there must be a balance between efforts placed on establishing appropriate supports for managing mental health and psychosocial calls as well as addressing necessary training and education in this area, while simultaneously ensuring sufficient focus remains at the level of prevention at the broader social, political, and economic determinants of physical and mental health. In their discussion of mental health and psychosocial calls, paramedics presented compelling accounts of the factors leading to and contributing to individuals' distress and crises. These factors are reflected in an understanding of mental health

through the SDOH that works toward reframing our understanding of mental health to include context and the realities of individuals' lived experiences in their distress.

Moving away from framing mental health concerns as 'illness' in no way negates the very real distress people are experiencing, but rather shifts the perspective to factors that create and exacerbate distress. The types of calls and circumstances seen by paramedics that may be described as 'mental health calls' or 'psychosocial calls' further informs not only the discussion around what is contributing to this volume of calls and means of addressing this issue but additionally, contributes to the academic and policy discussions around the SDOH and mental health equity. In working toward addressing a high volume of mental health and psychosocial calls to paramedic services, we must look beyond the paramedic services and even the mental health system to address policy and the social, political and economic structures impacting individuals' daily lived experiences and contributing to their distress.

References

- Adebimpe, V. R. (1981a). Overview: white norms and psychiatric diagnosis of black patients. *The American Journal of Psychiatry*, 138(3), 279-285.
- Adebimpe, V. R., Klein, H. E., & Fried, J. (1981b). Hallucinations and delusions in black psychiatric patients. *Journal of the National Medical Association*, 73(6), 517-520.
- Aho, K. (2008). Medicalizing mental health: A phenomenological alternative. *Journal of Medical Humanities*, 29(4), 243-249.
- Allen, J., Balfour, R., Bell, R., & Marmot, M. (2014). Social determinants of mental health. *International Review of Psychiatry*, 26(4), 392-407.
- Allsopp, K., & Kinderman, P. (2017). A proposal to introduce formal recording of psychosocial adversities associated with mental health using ICD-10 codes. *The Lancet Psychiatry*, 4(9), 664-665.
- Ambulance Act*, R.S.O. 1990, c. A.19 (Revised December 2017). Retrieved from <https://www.ontario.ca/laws/statute/90a19>
- Annual Report of the Office of the Auditor General of Ontario. (2016). *Ministry of Health and Long Term Care: Specialty Psychiatric Hospital Services*. Retrieved March 12, 2019 from http://www.auditor.on.ca/en/content/annualreports/arreports/en16/v1_312en16.pdf
- Arber, A. (2006). Reflexivity: a challenge for the researcher as practitioner?. *Journal of Research in Nursing*, 11(2), 147-157.
- Armstrong, P. (2013a). Puzzling skills: Feminist political economy approaches. *Canadian Review of Sociology/Revue canadienne de sociologie*, 50(3), 256-283.
- Armstrong (2013b). Skills for care. In Armstrong, P. & Braedley, S. (Eds). *Troubling care: Critical perspectives on research and practices*. Toronto: Canadian Scholars' Press Inc.
- Armstrong, P., Armstrong, H., & Coburn, D. (2001). The political economy of health and care. In Armstrong, P., Armstrong, H., & Coburn, D. (Eds). *Unhealthy Times: Political Economy Perspectives on Health and Care in Canada* (pp. vii-x). Toronto: Oxford University Press.
- Armstrong, P. & Braedley, S. (2013). Introduction. In Armstrong, P. & Braedley, S. (Eds). *Troubling Care: Critical Perspectives on Research and Practices* (pp. 9-11). Toronto: Canadian Scholars' Press Inc.
- Azarm-Daigle, M., Kuziemy, C. & Peyton, L. (2015). A review of cross organizational

- healthcare data sharing. *Procedia Computer Science*, 63, 425-432.
- Bailey, C. (2007). Practitioner to researcher: reflections on the journey. *Nurse Researcher*, 14(4), 18-26.
- Bambra, C., Fox, D., & Scott-Samuel, A. (2005). Towards a politics of health. *Health Promotion International*, 20(2), 187-193.
- Bambra, C., Gibson, M., Sowden, A., Wright, K., Whitehead, M., & Petticrew, M. (2010). Tackling the wider social determinants of health and health inequalities: Evidence from systematic reviews. *Journal of Epidemiology & Community Health*, 64(4), 284-291.
- Barken, R., Denton, M., Plenderleith, J., Zeytinoglu, I. U., & Brookman, C. (2015). Home care workers' skills in the context of task shifting: complexities in care work. *Canadian Review of Sociology/Revue canadienne de sociologie*, 52(3), 289-309.
- Barnes, G. E., & Toews, J. (1983). Deinstitutionalization of chronic mental patients in the Canadian context. *Canadian Psychology/Psychologie canadienne*, 24(1), 22-36.
- Baxter, P. & Jack, S. (2008). Qualitative case study methodology: Study design and implementation for novice researchers. *The Qualitative Report*, 13(4), 544-559.
- Beach, C., Croskerry, P., & Shapiro, M. (2003). Profiles in patient safety: emergency care transitions. *Academic emergency medicine*, 10(4), 364-367.
- Behara, R., Wears, R. L., Perry, S. J., Eisenberg, E., Murphy, L., Vanderhoef, M., & Cosby, K. (2005). A conceptual framework for studying the safety of transitions in emergency care. *Advances in Patient Safety*, 2, 309-321.
- Bell, C. C., & Mehta, H. (1980). The misdiagnosis of black patients with manic depressive illness. *Journal of the National Medical Association*, 72(2), 141-145.
- Bernard, R. (2013). *Social research methods: Qualitative and quantitative analysis*. Los Angeles: Sage.
- Bezanson, K. & Luxton, M. (2006). *Social Reproduction: Feminist Political Economy Challenges Neo-Liberalism*. Montreal & Kingston: McGill-Queen's University Press.
- Bigham, B., Kennedy, S., Drenan, I., & Morrison, L. (2013). Expanding paramedic scope of practice in the community: A systematic review of the literature. *Prehospital Emergency Care*, 17(3), 361-372.
- Bill 163: Supporting Ontario's First Responders Act (Posttraumatic Stress Disorder). (2016).

Retrieved March 12, 2019 from <https://www.ola.org/en/legislative-business/bills/parliament-41/session-1/bill-163>

- Bishop, V., Cassell, C. M., & Hoel, H. (2009). Preserving masculinity in service work: An exploration of the underreporting of customer anti-social behaviour. *Human Relations, 62*(1), 5-25.
- Bismah, V., Prpic, J., Michaud, S., & Sykes, N. (2017). P018: Prehospital diversion of mental health patients to a mental health center vs the emergency department: safety and compliance of an EMS direct transport protocol. *Canadian Journal of Emergency Medicine, 19*(S1), S83-S84.
- Blackwell, T. H., & Kaufman, J. S. (2002). Response time effectiveness: comparison of response time and survival in an urban emergency medical services system. *Academic Emergency Medicine, 9*(4), 288-295.
- Bolam, B., Gleeson, K., & Murphy, S. (2003, May). " Lay Person" or" Health Expert"? Exploring Theoretical and Practical Aspects of Reflexivity in Qualitative Health Research. In *Forum Qualitative Sozialforschung/Forum: Qualitative Social Research, 4*(2), 1-13.
- Bower, P., Knowles, S., Coventry, P. A., & Rowland, N. (2011). Counselling for mental health and psychosocial problems in primary care. Retrieved April 8, 2019 from http://www.easewellbeing.co.uk/PDF_Downloads/Cochrane_counselling_2011_update.pdf
- Bowles, R. (2009). From learning activities to the meaning of life: Fostering professionalism in Canadian paramedic education. *Australasian Journal of Paramedicine, 7*(4), 1-8.
- Bracken, P. & Thomas, P. (2005). The times they are a changing. In Bracken, P. & Thomas, P. (Eds.), *Postpsychiatry: Mental health in a postmodern world* (pp. 1-21). Oxford: Oxford University Press.
- Bracken, P., Thomas, P., Timimi, S., Asen, E., Behr, G., Beuster, C., Bhunnoo, S., Browne, I., China, N., Double, D., Downer, S., Evans, C., Fernando, S., Garland, M., Hopkins, W., Huws, R., Johnson, B., Martindale, B., Middleton, H., Moldavsky, D., Moncrieff, J., Mullins, S., Nelki, J., Pizzo, M., Rodger, J., Smyth, M., Summerfield, D., Wallace, J., & Yeomans, D. (2012). Psychiatry beyond the current paradigm. *The British Journal of Psychiatry, 201*(6), 430-434.

- Brady, M. (2012). Pre-hospital psychosocial care: changing attitudes. *Journal of Paramedic Practice*, 4(9), 516-525.
- Braedley, S. (2009). A ladder up: Ontario firefighters' wages in neoliberal times. *Just Labour*, 14, 129-149.
- Braedley, S. (2010). "Accidental" Health Care. In Braedley, S. & Luxton, M. (Eds.) *Neoliberalism and everyday life* (136-162). Montréal and Kingston: McGill-Queen's University Press.
- Braedley, S. (2012). The masculinization effect: Neoliberalism, the medical paradigm and Ontario's health care policy. *Canadian Woman Studies*, 29(3), 71-83.
- Braedley, S. (2015). Pulling men into the care economy: The case of Canadian firefighters. *Competition & Change*, 19(3), 264-278.
- Braedley, S. & Luxton, M. (2010). *Neoliberalism and Everyday Life*. Montréal and Kingston: McGill-Queen's University Press.
- Brassolotto, J. M. (2014). Querying everyday scarcity: A feminist political economy analysis of kidney dialysis and transplantation in rural British Columbia. (Doctoral dissertation, York University).
- Brassolotto, J., Raphael, D., & Baldeo, N. (2014). Epistemological barriers to addressing the social determinants of health among public health professionals in Ontario, Canada: a qualitative inquiry. *Critical Public Health*, 24(3), 321-336.
- Brassolotto, J., & Daly, T. (2016). Domesticating dialysis: A feminist political economy analysis of informal renal care in rural British Columbia. *The Canadian Geographer/Le Géographe canadien*, 60(4), 519-529.
- Braun, V. & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3(2), 77-101.
- Braun, V. & Clarke, V. (2014). What can "thematic analysis" offer health and wellbeing researchers? *International Journal of Qualitative Studies on Health and Well-being*, 9, 1-2.
- Brien, S., Grenier, L., Kapral, M., Kurdyak, P. & Vigod, S. (2015). Taking stock: A report on the quality of mental health and addictions services in Ontario. An HQO/ICES Report. Toronto, Health Quality Ontario and Institute for Clinical Evaluative Sciences. Retrieved

October 16, 2018 from <http://www.hqontario.ca/portals/0/Documents/pr/theme-report-taking-stock-en.pdf>

Bryman, A. & Teevan, J. J. (2005). *Social research methods*. Don Mills: Oxford University Press.

Burstow, B. (2013). A rose by any other name: Naming and the battle against psychiatry. In LeFrançois, B., Menzies, R. & Reaume, G. (Eds.) *Mad Matters: A Critical Reader in Canadian Mad Studies* (pp. 79-90). Toronto: Canadian Scholars' Press Inc.

Campbell, H., & Rasmussen, B. (2012). Riding third: Social work in ambulance work. *Health and Social Work, 37*(2), 90-97.

Canada Mortgage and Housing Corporation. (2018). 13.6% of Urban households were in core housing need in 2016. Retrieved April 10, 2019 from <https://www.cmhc-schl.gc.ca/en/housing-observer-online/2018-housing-observer/13-point-6-percent-urban-households-were-core-housing-need-2016>

Carleton, N., Afifi, T., Turner, S., Taillieu, T., Duranceau, S., LeBouthillier, D., Sareen, J., Ricciardelli, R., MacPhee, R., Groll, D., Hozempa, K., Brunet, A., Weekes, J., Griffiths, C., Abrams, K., Jones, N., Beshai, S., Cramm, H., Dobson, K., Hatcher, S., Keane, T., Stewart, S., & Asmundson, G. (2017). Mental disorder symptoms among public safety personnel in Canada. *The Canadian Journal of Psychiatry, 63*(1), 56-64.

Carney, T. (2008). The mental health service crises of neoliberalism – An antipodean perspective. *International Journal of Law and Psychiatry, 31*(2), 101-115.

Carter, N., Bryant-Lukosius, D., DiCenso, A., Blythe, J. & Neville, A. (2014). The use of triangulation in qualitative research. *Oncology Nursing Forum, 41*, 545-547.

Castañeda, H., Holmes, S., Madrigal, D., Young, M., Beyeler, N., & Quesada, J. (2015). Immigration as a social determinant of health. *Annual Review of Public Health, 36*, 375-392.

CBC News. (2012). EMS workers overloaded with mental health, addictions calls. Retrieved April 2, 2015 from <http://www.cbc.ca/news/canada/thunder-bay/ems-workers-overloaded-with-mental-health-addictions-calls-1.1171833>

CBC News. (2015). Paramedics oppose firefighters responding to medical emergency

- calls. Retrieved November 8, 2018 from <http://www.cbc.ca/news/canada/toronto/paramedics-oppose-firefighters-responding-to-medical-emergency-calls-1.3237311>
- CBC. (2018a). After the sirens. Retrieved January 16, 2019 from <https://www.cbc.ca/cbcdocs/pov/episodes/after-the-sirens>.
- CBC. (2018b). Ontario government legislates end to York University strike. Retrieved November 14, 2018 from <https://www.cbc.ca/news/canada/toronto/york-strike-end-1.4761835>
- Cheney, P., Haddock, T., Sanchez, L., Ernst, A., & Weiss, S. (2008). Safety and compliance with an emergency medical service direct psychiatric center transport protocol. *American Journal of Emergency Medicine*, 26(7), 750-756.
- Cheung, D. S., Kelly, J. J., Beach, C., Berkeley, R. P., Bitterman, R. A., Broida, R. I., ... & Klauer, K. M. (2010). Improving handoffs in the emergency department. *Annals of Emergency Medicine*, 55(2), 171-180.
- Chopra, D., (2013). A Feminist Political Economy Analysis of Public Policies Related to Care. Retrieved July 9, 2019 from <https://opendocs.ids.ac.uk/opendocs/bitstream/handle/123456789/2795/bitstream?sequence=1>
- City of Guelph. (2017). Community paramedicine program. Retrieved December 6, 2018 from <https://guelph.ca/living/emergency-services/ambulance-service/about-gwps/community-paramedicine-program/>
- Clark, M., Purdie, J., FitzGerald, G., Bischoff, N., O'Rourke, P. (1999). Predictors of demand for emergency prehospital care: An Australian study. *Prehospital and disaster medicine*, 14(3), 167-173.
- Clarke, D., Dusome, D., & Hughes, L. (2007). Emergency department from the mental health client's perspective. *International Journal of Mental Health Nursing*, 16(2), 126-131.
- Clement, W. (1997). *Understanding Canada: Building on the New Canadian Political Economy*. Kingston: McGill-Queen's University Press.
- Coffey, B., MacPhee, R., Socha, D. & Fischer, S. (2016). A physical demands description of paramedic work in Canada. *International Journal of Industrial Ergonomics*, 53, 355-362.
- Coleman, D., & Baker, F. M. (1994). Misdiagnosis of schizophrenia in older, black veterans. *Journal of Nervous and Mental Disease*, 182(9), 527-528.

- College of Nurses of Ontario. (2019). Approved nursing programs. Retrieved March 14, 2019 from <http://www.cno.org/en/become-a-nurse/approved-nursing-programs/>
- College of Respiratory Therapists of Ontario. (2019). Approved RT Programs. Retrieved March 14, 2019 from <https://www.crto.on.ca/student/registration/accredited-schools/>
- Compton, M. T., & Shim, R. S. (2015). The social determinants of mental health. *Focus*, 13(4), 419-425.
- Cooke, A., & Kinderman, P. (2018). “But What About Real Mental Illnesses?” Alternatives to the Disease Model Approach to “Schizophrenia”. *Journal of Humanistic Psychology*, 58(1), 47-71.
- Corman, M. (2017). Street medicine – Assessment work strategies of paramedics on the front lines of emergency health services. *Journal of Contemporary Ethnography*, 46(5), 600-623.
- Costa, L. (2013). Mad patients as legal intervenors in court. In LeFrançois, B., Menzies, R. & Reaume, G. (Eds.) *Mad Matters: A critical reader in Canadian Mad Studies*, (pp. 195-209). Toronto: Canadian Scholars’ Press Inc.
- Cotton, D. & Coleman, T. (2010). Canadian police agencies and their interactions with persons with a mental illness: a systems approach. *Police Practice and Research: An International Journal*, 11(4), 301-314.
- Crawford, R. (1980). Healthism and the medicalization of everyday life. *International Journal of Health Services*, 10(3), 365-388.
- Cresswell, T. (2004). Defining place. *Place: A Short Introduction*. Malden, MA: Blackwell Ltd
- Creswell, J. (2009). *Research design: Qualitative, quantitative, and mixed methods approaches*. Thousand Oaks: Sage.
- CSA Group. (2018). Psychological health and safety in the paramedic service organization. Retrieved April 16, 2019 from www.csagroup.org/paramedic-standard
- CTV London. (2015). Few options for those dealing with mental health crisis. Retrieved October 8, 2018 from <http://london.ctvnews.ca/few-options-for-those-dealing-with-mental-health-crisis-1.2297451>
- Cuddeback, G., Patterson, P. D., Moore, C. G., & Brice, J. H. (2010). Utilization of emergency medical transports and hospital admissions among persons with behavioral health conditions. *Psychiatric Services*, 61(4), 412-415.

- Curtis, S., Gesler, W., Smith, G. & Washburn, S. (2000). Approaches to sampling and case selection in qualitative research: examples in the geography of health. *Social Science and Medicine*, 50, 1001-1014.
- Daly, T. (2013). Imagining an ethos of care within policies, practices, and philosophy. In Armstrong, P. & Braedley, S. (Eds). *Troubling care: Critical perspectives on research and practices*. Toronto: Canadian Scholars' Press Inc.
- Daly, T., Banerjee, A., Armstrong, P., Armstrong, H., & Szebehely, M. (2011). Lifting the 'violence veil': Examining working conditions in long-term care facilities using iterative mixed methods. *Canadian Journal on Aging*, 30(2), 271-284.
- Daly, M. & Lewis, J. (2000). The concept of social care and the analysis of contemporary welfare states. *The British Journal of Sociology*, 51(2), 281-298.
- Davidson, L., Hoge, M., Godleski, L., Rakfeldt, J. & Griffith, E. (1996). Hospital or community living? Examining consumer perspectives on deinstitutionalization. *Psychiatric Rehabilitation Journal*, 19(3), 49-58.
- Davies, J. (2017). *The Sedated Society*. Basingstoke: Palgrave Macmillan.
- Davis, E. & Thompson, B. (2002). Emergency medical services field triage protocols accurately identify patients for direct psychiatric referral. *The Annals of Emergency Medicine*, 40(4), S54.
- Day, S. (2013). The implications of conceptualizing care. In Armstrong, P. & Braedley, S. (Eds). *Troubling care: Critical perspectives on research and practices*, (pp.21-31). Toronto: Canadian Scholars' Press Inc.
- Digel Vandyk, A., Young, L., MacPhee, C., & Gillis, K. (2018). Exploring the experiences of persons who frequently visit the emergency department for mental health-related reasons. *Qualitative health research*, 28(4), 587-599.
- Dejean, D., Giacomini, M., Welsford, M., Schwartz, L., & Decicca, P. (2016). Inappropriate ambulance use: a qualitative study of paramedics' views. *Healthcare Policy*, 11(3), 67.
- Donnelly, E. A., Cameron, A. A., Bucciachio, P., & Tong, J. (2017). Learning about behavioural emergencies: an evaluation of paramedic textbooks. *International Paramedic Practice*, 7(3), 37-41.
- Donnelly, E. A., Chonody, J., & Campbell, D. (2014). Measuring chronic stress in the emergency medical services. *Journal of workplace behavioral health*, 29(4), 333-353.

- Durbin, J., Goering, P., Streiner, D. & Pink, G. (2006). Does systems integration affect continuity of mental health care? *Administrative Policy in Mental Health and Mental Health Services Research*, 33(6), 705-717.
- Dyck, I., Kontos, P., Angus, J., & McKeever, P. (2005). The home as a site for long-term care: meanings and management of bodies and spaces. *Health & place*, 11(2), 173-185.
- Edmiston, J. (2014). Toronto EMS to change its name to 'Paramedic Services' to make it clear that a paramedic is coming to the rescue. *National Post*. Retrieved February 18, 2019 from <https://nationalpost.com/news/toronto-ems-to-change-its-name-to-paramedic-services-to-make-it-clear-that-a-paramedic-is-coming-to-the-rescue>
- Edwards, D. (2011). Paramedic preceptor: work readiness in graduate paramedics. *The Clinical Teacher*, 8(2), 79-82.
- Edwards, V., Holden, G., Felitti, V., & Anda, R. (2003). Relationship between multiple forms of childhood maltreatment and adult mental health in community respondents: Results from the adverse childhood experiences study. *American Journal of Psychiatry*, 160(8), 1453-1460.
- Emond, K., Furness, S., & Deacon-Crouch, M. (2015). Undergraduate paramedic students' perception of mental health using a pre and post questionnaire. *Australasian Journal of Paramedicine*, 12(5), 1-6.
- Emond, K., O'Meara, P. & Bish, M. (2019). Paramedic management of mental health related presentations: a scoping review. *Journal of Mental Health*, 28 (1), 89-96.
- Engel, G. L. (1977). The need for a new medical model: a challenge for biomedicine. *Science*, 196(4286), 129-136.
- England, K. V. (1994). Getting personal: Reflexivity, positionality, and feminist research. *The Professional Geographer*, 46(1), 80-89.
- Esposito, L. & Perez, F. (2014). Neoliberalism and the commodification of mental health. *Humanity and Society*, 38(4), 414-442.
- Fernando, S. (2010). *Mental health, race, and culture*. Basingstoke: Palgrave MacMillan.
- Filstad, C. (2010). Learning to be a competent paramedic: emotional management in emotional work. *International Journal of Work Organisation and Emotion*, 3(4), 368-383.
- Findlay, R. A. (2003). Interventions to reduce social isolation amongst older people: where is the evidence?. *Ageing & Society*, 23(5), 647-658.

- Fisher, M. & Baum, F. (2010). The social determinants of mental health: Implications for research and health promotion. *Australia and New Zealand Journal of Psychiatry*, 44(12), 1057-1063.
- Ford-Jones, P. & Chaufan, C. (2017). A critical analysis of mental health calls in the prehospital setting. *Inquiry: The Journal of Health Care Organization, Provision, and Financing*, 54, 1-5.
- Freeze, (2018). Paramedics in Canada More Likely to Experience Suicidal Ideation Study Finds. Retrieved July 12, 2019 from <https://www.theglobeandmail.com/news/national/paramedics-in-canada-more-likely-to-experience-suicidal-ideation-study-finds/article38045978/>
- Fuller, J., Edwards, J., Procter, N., & Moss, J. (2000). How definition of mental health problems can influence help seeking in rural and remote communities. *Australian Journal of Rural Health*, 8(3), 148-153.
- Gamble, R., Stevens, A., McBrien, H., Black, A., Cran, G. & Boreham, C. (1991). Physical fitness and occupational demands of the Belfast ambulance service. *British Journal of Industrial Medicine*, 48(9), 592-596.
- Geoffrion, S., Lanctôt, N., Marchand, A., Boyer, R., & Guay, S. (2015). Predictors of trivialization of workplace violence among healthcare workers and law enforcers. *Journal of Threat Assessment and Management*, 2(3), 195-213.
- Giandinoto, J. A., Stephenson, J., & Edward, K. L. (2018). General hospital health professionals' attitudes and perceived dangerousness towards patients with comorbid mental and physical health conditions: Systematic review and meta-analysis. *International Journal of Mental Health Nursing*, 27(3), 942-955.
- Gifford, M. & Anderson, J. (2010). Barriers and motivating factors in reporting incidents of assault in mental health care. *Journal of the American Psychiatric Nurses Association*, 16(5), 288-298.
- Gillespie, G., Gates, D., Miller, M., & Howard, P. (2010). Workplace violence in healthcare settings: Risk factors and protective strategies. *Rehabilitation Nursing*, 35, (5), 177-184.
- Glaser, B. (1965). The constant comparative method of qualitative analysis. *Social Problems*, 12(4), 436-445.
- Gordon, J. A. (1999). The hospital emergency department as a social welfare institution. *Annals*

- of Emergency Medicine*, 33(3), 321-325.
- Haley, E. (2017). Transinstitutionalization: A feminist political economy analysis of Ontario's public mental health care system. (Doctoral dissertation, York University).
- Hankivsky, O. & Christoffersen, A. (2008). Intersectionality and the determinants of health: A Canadian perspective. *Critical Public Health*, 18(3), 271-283.
- Hanna, L. (1998). Chronic manic depressives, schizoaffectives and their female family caregivers: The political economy of mental health care and the governance of madness. (Doctoral dissertation, Carleton University).
- Hartford, K., Schrecker, T., Wiktorowicz, M., Hock, J., Sharp, C. (2003). Four decades of mental health policy in Ontario, Canada. *Admin and Policy in Mental Health*, 31(1), 65-73.
- Harvey, D. (2005). *A Brief History of Neoliberalism*. Oxford: Oxford University Press.
- Hawley, C., Singhal, A., Roberts, A., Aktinson, H. & Whelan, C. (2011). Mental health in the care of paramedics: Part 1: *Journal of Paramedic Practice*, 3(5), 230-236.
- Health Care Consent Act (1996, c. 2 Sched. A). Retrieved from <https://www.ontario.ca/laws/statute/96h02>
- Heslop, L., Stitt, L. & Hoch, J. (2011). *Trends in Police Contact with Persons with Mental Illness*. London, Ontario. Retrieved November 10, 2018 from <http://capg.ca/wp-content/uploads/2013/05/Trends-in-Police-Contact-with-Persons-with-Mental-Illness-Report-for-LPSB-2013.pdf>
- Hewitt, J. L. (2008). Dangerousness and mental health policy. *Journal of Psychiatric and Mental Health Nursing*, 15(3), 186-194.
- Hochschild, A. R. (1979). Emotion work, feeling rules, and social structure. *American Journal of Sociology*, 85(3), 551-575.
- Hochschild, A. R. (1983). *The managed heart*. Berkeley: University of California Press.
- Hou, X. Y., Rego, J., & Service, M. (2013). Paramedic education opportunities and challenges in Australia. *Emergency Medicine Australasia*, 25(2), 114-119.
- Jones, B. E., & Gray, B. A. (1986). Problems in diagnosing schizophrenia and affective disorders among blacks. *Psychiatric Services*, 37(1), 61-65.
- Kearns, R., & Moon, G. (2002). From medical to health geography: novelty, place and theory after a decade of change. *Progress in Human Geography*, 26(5), 605-625.

- Kerrison, S. A., & Chapman, R. (2007). What general emergency nurses want to know about mental health patients presenting to their emergency department. *Accident and Emergency Nursing, 15*(1), 48-55.
- Kinderman, P. (2015). Imagine there's no diagnosis, it's easy if you try. *Psychopathology Review, 2*(1), 154-161.
- Kinderman, P. (2017). A manifesto for psychological health and wellbeing. In Kinderman P. (Ed). *The Sedated Society* (pp. 271-301). London: Palgrave Macmillan.
- Krueger & Casey. (2000). Focus groups: A practical guide for applied research. Sage Publications: United States of America.
- Lam, S. S. W., Zhang, J., Zhang, Z. C., Oh, H. C., Overton, J., Ng, Y. Y., & Ong, M. E. H. (2015). Dynamic ambulance reallocation for the reduction of ambulance response times using system status management. *The American journal of emergency medicine, 33*(2), 159-166.
- Lamb, H. R., Weinberger, L. E., & DeCuir Jr, W. J. (2002). The police and mental health. *Psychiatric services, 53*(10), 1266-1271.
- Larkin, G. L., Claassen, C. A., Emond, J. A., Pelletier, A. J., & Camargo, C. A. (2005). Trends in US emergency department visits for mental health conditions, 1992 to 2001. *Psychiatric Services, 56*(6), 671-677.
- Larkin, G., Claassen, C., Pelletier, A., & Camargo, C. (2006). National study of ambulance transports to United States Emergency Departments: Importance of mental health problems. *Prehospital and Disaster Medicine. 21*(2), 82-90.
- Larkin, G. L., Beautrais, A. L., Spirito, A., Kirrane, B. M., Lippmann, M. J., & Milzman, D. P. (2009). Mental health and emergency medicine: a research agenda. *Academic Emergency Medicine, 16*(11), 1110-1119.
- Larsson, P. (2013). The rhetoric/reality gap in social determinants of mental health. *Mental Health Review Journal, 18*(4), 182-193.
- Lau, H. S., Hollander, M. M., Cushman, J. T., DuGoff, E. H., Jones, C. M., Kind, A. J., ... & Shah, M. N. (2018). Qualitative evaluation of the coach training within a community paramedicine care transitions intervention. *Prehospital Emergency Care, 22*(4), 527-534.
- LeFrançois, B., Menzies, R. & Reaume, G. (2013). Mad Matters: A critical reader in Canadian Mad Studies. Toronto: Canadian Scholars' Press Inc.

- Letvak, S. (2002). The importance of social support for rural mental health. *Issues in mental health nursing*, 23(3), 249-261.
- Lexchin, J. (2012). Those who have the gold make the evidence: how the pharmaceutical industry biases the outcomes of clinical trials of medications. *Science and Engineering Ethics*, 18(2), 247-261.
- Litoselliti, L. (2003). Using focus groups in research. Continuum: London.
- Logie, C. (2012). The case for the World Health Organization's Commission on the Social Determinants of Health to address sexual orientation. *American journal of public health*, 102(7), 1243-1246.
- Lowthian, J. A., Cameron, P. A., Stoelwinder, J. U., Curtis, A., Currell, A., Cooke, M. W., & McNeil, J. J. (2011). Increasing utilisation of emergency ambulances. *Australian Health Review*, 35(1), 63-69.
- Luxton, M., & Bezanson, K. (Eds.). (2006). *Social reproduction: Feminist political economy challenges neo-liberalism*. McGill-Queen's Press.
- Magnavita, N. (2014). Workplace violence and occupational stress in healthcare workers: A chicken-and-egg situation – Results of a 6-year follow-up Study. *Journal of Nursing Scholarship*, 46(5), 366-376.
- Malcoe, L. & Morrow, M. (2017). Introduction: Science, social (in)justice, and mental health. In Morrow, M. & Malcoe, L. (Eds) *Critical Inquiries for Social Justice in Mental Health*, (pp. 3-30). Toronto: University of Toronto Press.
- Malla, A., Joobar, R., & Garcia, A. (2015). "Mental illness is like any other medical illness": a critical examination of the statement and its impact on patient care and society. *Journal of Psychiatry and Neuroscience*, 40(3), 147-150.
- Mann, S. (2005). A health-care model of emotional labour: an evaluation of the literature and development of a model. *Journal of health organization and management*, 19(4/5), 304-317.
- Manser, T., Foster, S., Gisin, S., Jaeckel, D., & Ummenhofer, W. (2010). Assessing the quality of patient handoffs at care transitions. *Qual Saf Health Care*, 19(6), e44-e44.
- Marmot, M. (2005). Social determinants of health inequalities. *The Lancet*, 365(9464), 1099-1104.
- Martin, A., O'meara, P., & Farmer, J. (2016). Consumer perspectives of a community

- paramedicine program in rural Ontario. *Australian Journal of Rural Health*, 24(4), 278-283.
- Marynowski-Traczyk, D., Moxham, L., & Broadbent, M. (2013). A critical discussion of the concept of recovery for mental health consumers in the Emergency Department. *Australasian Emergency Nursing Journal*, 16(3), 96-102.
- Masroor, M., Schlesinger, S. A., Nguyen, T. H., Koenig, K. L., Schultz, C. H., & Miler, K. (2016). 121 Paramedics Receiving Training in Low Acuity Complaints Demonstrate Safety in Alternate Destination Disposition Recommendations. *Annals of Emergency Medicine*, 68(4), S48.
- McCann, L., Granter, E., Hyde, P., & Hassard, J. (2013). Still blue-collar after all these years? An ethnography of the professionalization of emergency ambulance work. *Journal of Management Studies*, 50(5), 750-776.
- McCann, T., Savic, M., Ferguson, N., Bosley, E., Smith, K., Roberts, L., Emond, K., & Lubman, D. (2018). Paramedics' perceptions of their scope of practice in caring for patients with non-medical emergency-related mental health and/or alcohol and other drug problems: A qualitative study. *PlosOne*, 13(2), 1-16.
- McNamara, M. B. (2016). *"Saving Lives; Living the Dream": Gender and Emotional Labor Among Ambulance-Based 911 Paramedics* (Doctoral dissertation, UC Santa Cruz).
- McPhaul, K., Lipscomb, J. (2004). Workplace violence in health care: Recognized but not regulated. *Online Journal of Issues in Nursing*, 9(3) 1-14.
- McGruder, J. (2002). Life experience is not a disease or why medicalizing madness is counterproductive to recovery. *Occupational Therapy in Mental Health*, 17(3-4), 59-80.
- Mental Health Act*, R.S.O. 1990, c. M.7 (Revised December 2015). Retrieved from <https://www.ontario.ca/laws/statute/90m07>
- Metz, D. (1981). *Running hot: Structures and stress in ambulance work*. Cambridge, MA: Abt Books.
- Metzl, J. M. (2010). *The protest psychosis: How schizophrenia became a black disease*. Boston: Beacon Press.
- Mi, R., Hollander, M. M., Jones, C. M., DuGoff, E. H., Caprio, T. V., Cushman, J. T., ... & Shah, M. N. (2018). A randomized controlled trial testing the effectiveness of a paramedic-delivered care transitions intervention to reduce emergency department revisits. *BMC*

- Geriatrics*, 18(1), 104.
- Mikkonen, J., & Raphael, D. (2010). *Social determinants of health: The Canadian facts*. Retrieved September 14, 2018 from http://thecanadianfacts.org/the_canadian_facts.pdf
- Miles, M. B., Huberman, A. M., Huberman, M. A., & Huberman, M. (1994). *Qualitative data analysis: An expanded sourcebook*. London: Sage.
- Milligan, C. (2005). Without these walls: a geography of mental ill-health in a rural environment. In Butler, R. & Parr, H. (Eds.) *Mind and Body Spaces* (pp. 229-248). London: Routledge.
- Milligan, C., & Power, A. (2010). The changing geography of care. In (Eds.) Brown, T., McLafferty, S., & Moon, G. *A companion to health and medical geography*, (pp.567-586). Chichester: Blackwell Publishing Ltd.
- Milligan, C., & Wiles, J. (2010). Landscapes of care. *Progress in Human Geography*, 34(6), 736-754.
- Mills, C. (2015). The psychiatrization of poverty: Rethinking the mental health-poverty nexus. *Social and Personality Psychology Compass*, 9(5), 213-222.
- Ministry of Health and Long Term Care. (2012). *Ambulance Services Billing*. Retrieved March 8, 2019 from www.health.gov.on.ca/en/public/publications/ohip/amb.aspx
- Ministry of Health and Long Term Care. (2013). Annual Report of the Office of the Auditor General of Ontario, 2013. Retrieved March 28, 2019 from http://www.auditor.on.ca/en/content/annualreports/arreports/en13/2013ar_en_web.pdf
- Ministry of Health and Long Term Care. (2015). Living Standards Project Change Request Form. Emergency Health Services Branch. Retrieved November 2, 2018 from <https://www.oapc.ca/wp-content/uploads/2017/04/Living-Standard-Project-Change-Request-Form-Trach.pdf>
- Ministry of Health and Long Term Care (2016). Training Bulletin: BLS PCS v3.0 Summary of Changes. Emergency Health Services Branch. Retrieved September 4, 2018 from <https://www.lhsc.on.ca/media/2930/download>
- Ministry of Health and Long-Term Care. (2018a). *ALS: Advanced life support patient care standards*, Version 4.4. Emergency Health Services Branch. Retrieved January 10, 2019 from http://www.health.gov.on.ca/en/pro/programs/emergency_health/edu/docs/als_pcs_v4.4.pdf

- Ministry of Health and Long-Term Care. (2018b). *BLS: Basic life support patient care standards*, Version 3.0.1. Emergency Health Services Branch. Retrieved January 10, 2019 from <https://www.lhsc.on.ca/media/2899/download>
- Ministry of Health and Long Term Care. (2018c). Emergency Health Services. Retrieved September 24, 2018 from http://www.health.gov.on.ca/en/pro/programs/emergency_health/default.aspx
- Ministry of Health and Long Term Care (2018d). Emergency Health Services: Certification and Patient Care Standards Overview. Retrieved April 2, 2019 from http://health.gov.on.ca/en/pro/programs/emergency_health/edu/standards_exams.aspx
- Ministry of Health and Long Term Care (2018e). Emergency health services: Controlled acts under regulation 257/00. Retrieved September 10, 2018 from http://www.health.gov.on.ca/en/pro/programs/emergency_health/reg_257_00.aspx
- Ministry of Health and Long Term Care. (2018f). *Medical Education*. Retrieved September 20, 2018 from http://www.health.gov.on.ca/en/pro/programs/hhrsd/physicians/medical_education.aspx
- Ministry of Health and Long Term Care (2018g). *Ontario's Emergency Health Services: Sector Overview*. Retrieved from <https://agendasonline.greatersudbury.ca/index.cfm?pg=feed&action=file&agenda=report&itemid=4&id=1278>
- Ministry of Training, Colleges and Universities. (2018). *Paramedic Program Standard*. Retrieved December 4, 2018 from <http://www.tcu.gov.on.ca/pepg/audiences/colleges/progstan/health/paramedic.pdf>
- Morrow, M. (2017). Women and Madness Revisited': The Promise of Intersectional and Mad Studies Frameworks. In Morrow, M. & Malcoe, L. (Eds) *Critical Inquiries for Social Justice in Mental Health* (pp. 33-59). Toronto: University of Toronto Press.
- Morrow, M., & Weisser, J. (2012). Towards a Social Justice Framework of Mental Health Recovery. *Studies in Social Justice*, 6(1), 27-43.
- Morse, J. M. (Ed.). (1994). *Critical issues in qualitative research methods*. London: Sage.
- Mulholland, P. O'Meara, P. Walker, J. Stirling, C., Tourle, V. (2009). Multidisciplinary practice in action: The rural paramedic-it's not only lights and sirens. *Australasian Journal of Paramedicine*, 7(2).

- Mulvale, G., Abelson, J., & Goering, P. (2007). Mental health service delivery in Ontario, Canada: How do policy legacies shape prospects for reform?. *Health Economics, Policy and Law*, 2(4), 363-389.
- Munjal, K. G., Shastry, S., Loo, G. T., Reid, D., Grudzen, C., Shah, M. N., Chapin, H., First, B., Sirirungruang, S., Alpert, E., Chason, K. & Richardson, L. (2016). Patient perspectives on EMS alternate destination models. *Prehospital Emergency Care*, 20(6), 705-711.
- Munro, G., O'Meara, P., & Kenny, A. (2016). Paramedic Transition into an Academic Role in Universities: A demographic and qualification survey of paramedic academics in Australia and New Zealand. *Irish Journal of Paramedicine*, 1(2), 1-11.
- Murphy, E. & Dingwall, R. (2007). Informed consent, anticipatory regulation and ethnographic practice. *Social Science & Medicine*, 65, 2223-2234.
- Navarro, V. (2007). Neoliberalism as a class ideology; or, the political causes of the growth of inequalities. *International Journal of Health Services*, 37(1), 47-62.
- Nelson, G., Lord, J., Ochocka, J. (2001). *Shifting the Paradigm in Community Mental Health*. Toronto: University of Toronto Press.
- New Brunswick Health Council. (2016). Ontario community paramedicine program aims to keep patients at home longer. Retrieved April 2, 2019 from <https://www.nbhc.ca/ontario-community-paramedicine-pilot-program-aims-keep-patients-home-longer#.W5q8Ei3MygA>
- News Ontario. (2017). Unique pilot project helping seniors in Northeastern Ontario live independently at home. Retrieved April 2, 2019 from <https://news.ontario.ca/opo/en/2017/05/unique-pilot-project-helping-seniors-in-northeastern-ontario-live-independently-at-home.html>
- Newton, A. S., Ali, S., Johnson, D. W., Haines, C., Rosychuk, R. J., Keaschuk, R. A., ... & Klassen, T. P. (2010). Who comes back? Characteristics and predictors of return to emergency department services for pediatric mental health care. *Academic Emergency Medicine*, 17(2), 177-186.
- Nicks, B. A., & Manthey, D. M. (2012). The impact of psychiatric patient boarding in emergency departments. *Emergency Medicine International*, 1-5.
- O'Brien, K., Moore, A., Dawson, D., & Hartley, P. (2014). An Australian story: paramedic education and practice in transition. *Australasian Journal of Paramedicine*, 11(3), 1-13.

- O'Hara, R., Johnson, M., Siriwardena, A. N., Weyman, A., Turner, J., Shaw, D., Mortimer, P., Newman, C., Hirst, E., Storey, M., Mason, S., Quinn, T. & Shewan, J. (2015). A qualitative study of systemic influences on paramedic decision making: care transitions and patient safety. *Journal of Health Services Research & Policy*, 20(1), 45-53.
- O'Meara, P. F., Tourle, V., Stirling, C., Walker, J., & Pedler, D. (2012). Extending the paramedic role in rural Australia: a story of flexibility and innovation. *Rural and Remote Health*, 12(2), 1-13.
- O'Meara, P., Wingrove, G., & Nolan, M. (2017). Clinical leadership in paramedic services: a narrative synthesis. *International Journal of Health Governance*, 22(4), 251-268.
- Ontario Base Hospital Group. (2018). About us. Retrieved September 14, 2018 from <http://www.ontariobasehospitalgroup.ca/About+Us/default.aspx>
- Ontario Colleges (2018). Paramedics. Retrieved September 14, 2018 from <https://www.ontariocolleges.ca/en/programs/health-food-and-medical/paramedic>
- Ontario Paramedic Association. (2015). History of paramedics in Ontario. Retrieved September 18, 2018 from <https://www.ontarioparamedic.ca/before-9-1-1/history-of-paramedics-in-ontario>
- Ontario Paramedic Association. (2018). Paramedics. Retrieved December 10, 2018 from <https://www.ontarioparamedic.ca/curriculum/primary-care-paramedics/>
- Ontario Paramedic Association. (2019). Paramedic self-regulation. Retrieved April 14, 2019 from <https://www.ontarioparamedic.ca/self-regulation/>
- Ottawa Citizen. (2007). Give paramedics psychiatric training: coroner's jury. Retrieved March 20, 2015 from http://www.canada.com/story.html?id=2de9be73-d834-42fc-ad40-6d1bf84bf543#_federated=1.
- Parr, H., & Philo, C. (2003). Rural mental health and social geographies of caring. *Social & Cultural Geography*, 4(4), 471-488.
- Parr, H., Philo, C., & Burns, N. (2004). Social geographies of rural mental health: experiencing inclusions and exclusions. *Transactions of the Institute of British Geographers*, 29(4), 401-419.
- Parsons, V. & O'Brien, L. (2011) Paramedic clinical decision-making in mental health care: a new theoretical approach. *Journal of Paramedic Practice*, 3(10), 572-579.
- Patel, V., Lund, C., Hatherill, S., Plagerson, S., Corrigan, J., Funk, M., & Flisher, A. J. (2010).

- Mental disorders: equity and social determinants. In Blas, E. & Kurup, S. (Eds.) *Equity, social determinants and public health programmes*, (pp.115-134). Geneva: WHO Press.
- Poole, J., & Ward, J. (2013). Breaking open the bone: Storying, sanism and mad grief. In LeFrançois, B., Menzies, R. & Reaume, G. (Eds.) *Mad Matters: A critical reader in Canadian mad studies* (pp. 94-104). Toronto: Canadian Scholars' Press Inc.
- Pope, C. (2005). Conducting ethnography in medical settings. *Medical Education*, 39(12), 1180-1187.
- Porter (2012). *EMS workers overloaded with mental health, addictions calls*. CBC News. Retrieved March 20, 2015 from <http://www.cbc.ca/news/canada/thunder-bay/ems-workers-overloaded-with-mental-health-addictions-calls-1.1171833>
- Prairie, J. & Corbeil, P. (2014). Paramedics on the job: Dynamic trunk motion assessment at the workplace. *Applied Ergonomics*, 45(4), 895-903.
- Prener, C. & Lincoln, A. (2015). Emergency medical services and “Psych Calls”: Examining the work of urban EMS providers. *American Journal of Orthopsychiatry*, 85(6), 612-619.
- Quimby, E. (2006). Ethnography’s role in assisting mental health research and clinical practice. *Journal of Clinical Psychology*, 62(7), 859-879.
- Raphael D. (2009a). Restructuring society in the service of mental health promotion: Are we willing to address the social determinants of mental health? *International Journal of Mental Health Promotion*, 11(3), 18-31.
- Raphael, D., Ed. (2009b). *Social Determinants of Health: Canadian Perspectives*, 2nd edition. Toronto: Canadian Scholars' Press Incorporated.
- Reavley, N. J., Jorm, A. F., & Morgan, A. J. (2016). Beliefs about dangerousness of people with mental health problems: the role of media reports and personal exposure to threat or harm. *Social Psychiatry and Psychiatric Epidemiology*, 51(9), 1257-1264.
- Registered Practical Nurses Association of Ontario. (2019). *How do I become an RPN?* Retrieved April 10, 2019 from <https://www.rpnao.org/rpncareers/how-rpn>
- Richman, A. & Harris, P. (1982). Mental hospital deinstitutionalization in Canada: A national perspective with some regional examples. *International Journal of Mental Health*, 11(4), 64-83.
- Riley, R., & Weiss, M. C. (2016). A qualitative thematic review: emotional labour in healthcare settings. *Journal of Advanced Nursing*, 72(1), 6-17.

- Roberts, L., Henderson, J., Willis, E. & Muir-Cochrane, E. (2013). The challenges of gaining ethics approval for ethnographic research in the pre-hospital setting. *Journal of Psychiatric and Mental Health Nursing*, 20(4), 374-378.
- Roggenkamp, R., Andrew, E., Nehme, Z., Cox, S. & Smith, K. (2018). Descriptive analysis of mental health-related presentation to emergency medical services. *Prehospital Emergency Care*, 22(4), 399-405.
- Rose, N. (2003). Neurochemical selves. *Society*, 41(1), 46-59.
- Ryan, W. (1976). *Blaming the victim*. New York: Vintage.
- Savage, J. (2006). Ethnographic evidence: The value of applied ethnography in healthcare. *Journal of Research in Nursing*, 11(5), 383-393.
- Sealy, P. & Whitehead, P. (2004). Forty years of deinstitutionalization of psychiatric services in Canada: An empirical assessment. *Canadian Journal of Psychiatry*, 49, 249-257.
- Service Canada. (2015). Ambulance Attendants and Other Paramedical Occupations. Retrieved Sept 10, 2018 from <http://noc.esdc.gc.ca/English/NOC/Profile.aspx?val=3&val1=3234&ver=06>
- Shaban, R. (2005a). Accounting for assessments of mental illness in paramedic practice: A new theoretical framework. *Journal of Emergency Primary Health Care*, 3(3), 1-10.
- Shaban, R. (2005b). Paramedic clinical judgment of mental illness: Representations of official accounts. *Journal of Emergency Primary Health Care*, 3(4), 1-10.
- Shaban, R. (2006). Paramedics' clinical judgement and mental health assessments in emergency contexts: Research, practice, and tools of the trade. *Journal of Emergency Primary Health Care*, 4(2), 13p.
- Shapiro, G. K., Cusi, A., Kirst, M., O'Campo, P., Nakhost, A., & Stergiopoulos, V. (2015). Co-responding police-mental health programs: a review. *Administration and policy in mental health and mental health services research*, 42(5), 606-620.
- Sherwin, S. (1996). Theory versus practice in Ethics: A feminist perspective on justice in health care. In Sumner, L. & Boyle, J. (Eds.) *Philosophical Perspective on Bioethics* (pp-187-209). Toronto: University of Toronto Press.
- Shim, R., Koplan, C., Langheim, F. J., Manseau, M. W., Powers, R. A., & Compton, M. T. (2014). The social determinants of mental health: An overview and call to action. *Psychiatric Annals*, 44(1), 22-26.

- Shimrat, I. (2013). The tragic farce of “community mental health care” in LeFrançois, B., Menzies, R. & Reaume, G. (Eds). *Mad Matters: A critical reader in Canadian Mad Studies*, (pp. 144-157). Toronto: Canadian Scholars’ Press Inc.
- Simmons, H. (1990). *Unbalanced: Mental health policy in Ontario, 1930-1989*. Toronto: Wall & Tomphons
- Smith, D. (1989). Feminist reflections on political economy. *Studies in Political Economy*, 30(1), 37-59.
- Smith, D. E. (1990). *The conceptual practices of power: A feminist sociology of knowledge*. University of Toronto Press.
- Smith, K. B., Humphreys, J. S., & Wilson, M. G. (2008). Addressing the health disadvantage of rural populations: how does epidemiological evidence inform rural health policies and research?. *Australian Journal of Rural Health*, 16(2), 56-66.
- Snooks, H. A., Dale, J., Hartley-Sharpe, C., & Halter, M. (2004). On-scene alternatives for emergency ambulance crews attending patients who do not need to travel to the accident and emergency department: a review of the literature. *Emergency Medicine Journal*, 21(2), 212-215.
- Sofianopoulos, S., Williams, B. & Archer, F. (2012). Paramedics and the effects of shift work on sleep: a literature review. *Emergency Medicine Journal*, 29(2), 152-155.
- Sollows, E. (2015). *Paramedics may be lacking mental health training*. UNews. Retrieved March 20, 2015 from <http://unews.ca/paramedics-may-be-lacking-mental-health-training/>.
- Speroni, K., Fitch, T., Dawson, E., Dugan, L., & Atherton, M. (2014). Incidence and cost of nurse workplace violence perpetrated by hospital patients or patient visitors. *Journal of Emergency Nursing*, 40(3), 218-228.
- Statistics Canada (2016). Statistics Canada Census Profile. Retrieved March 10, 2019 from <https://www12.statcan.gc.ca/census-recensement/2016/dp-pd/prof/index.cfm?Lang=E>
- Steadman, H. J., Deane, M. W., Borum, R., & Morrissey, J. P. (2000). Comparing outcomes of major models of police responses to mental health emergencies. *Psychiatric Services*, 51(5), 645-649.
- Stirling, C., O’Meara, P., Pedler, D., Tourle, V. & Walker, J. (2007). Engaging rural communities in health care through a paramedic expanded scope of practice. *Rural and*

Remote Health, 7(4), 1-9.

Strudwick, P. (2013). Dinesh Bhugra: Psychiatry needs a broader focus. *The Guardian*.

Retrieved October 2, 2018 from <https://www.theguardian.com/society/2013/nov/27/dinesh-bhugra-psychiatry-mental-illness>

Struthers, J. (2013). Historical perspectives on care and the welfare state: The rise, retreat, return, and reframing of a key concept. In Armstrong, P. & Braedley, S. (Eds). *Troubling care: Critical perspectives on research and practices*, (pp.159-170). Toronto: Canadian Scholars' Press Inc.

Szasz, T. (1960). The myth of mental illness. *American Psychologist*, 15(2), 113-118.

Szasz, T. (1997). *The manufacture of madness: A comparative study of the inquisition and the mental health movement*. New York: Syracuse University Press.

Tavares, W., Boet, S., Theriault, R., Mallette, T., & Eva, K. W. (2013). Global rating scale for the assessment of paramedic clinical competence. *Prehospital emergency care*, 17(1), 57-67.

Tavares, W., Bowles, R. & Donelon, B. (2016). Informing a Canadian paramedic profile: framing concepts, roles and crosscutting themes, *BMC Health Services Research*, 16(477), 1-16.

Tavares, W., Drennan, I., Van Diepen, K., Abanil, M., Kedzierski, N., Spearen, C., Barrette, N. & Mercuri, M. (2017). Building capacity in healthcare by re-examining clinical services in paramedicine. *Prehospital Emergency Care*, 21(5), 652-661.

Teghtsoonian, K. (2009). Depression and mental health in neoliberal times: A critical analysis of policy and discourse. *Social Science and Medicine*, 69(1), 28-35.

Teller, J. L., Munetz, M. R., Gil, K. M., & Ritter, C. (2006). Crisis intervention team training for police officers responding to mental disturbance calls. *Psychiatric services*, 57(2), 232-237.

Thomas, J. (1993). *Doing Critical Ethnography*. Newbury Park: Sage Publications.

Thompson, S. (2015). The perceived concerns of newly qualified paramedics commencing their careers: a pilot study. *Journal of Paramedic Practice*, 7(2), 74-78.

Thornicroft, G. & Tansella, M. (2004). Components of a modern mental health service: A pragmatic balance of community and hospital care. *British Journal of Psychiatry*, 185(4), 283-290.

- Ussher, J. M. (1991). *Women's madness: Misogyny or mental illness?*. Amherst: University of Massachusetts Press.
- Ussher, J. M. (2011). *The madness of women: Myth and experience*. New York: Routledge.
- Vandonk, T. (2014). Peterborough paramedics increasing an increase of mental health calls. *MyKawartha News*. Retrieved March 4, 2015 from <http://www.mykawartha.com/news-story/5025248-peterborough-paramedics-experiencing-an-increase-of-mental-health-calls/>
- Vaughn, A., Ly, M., Andresen, A., Wuschke, K., Hodgkinson, T., & Campbell, A. (2018). Concentrations and specialization of mental health-related calls for police service. *An International Journal of Evidence-Based Research, Policy and Practice*, 13(8), 1153-1170.
- Verma, A., Klich, J., Thurston, A., Scantlebury, J., Kiss, A., Seddon, G. & Sinha, S. (2018). Paramedic-initiated home care referrals and use of home care and emergency medical services. *Prehospital Emergency Care*, 22(3), 279-384.
- Vilke, G., Bozeman, W., Dawes, D., Demers, G. & Wilson, M. (2012). Excited delirium syndrome (ExDS): Treatment options and considerations. *Journal of Forensic and Legal Medicine*, 19(3), 117-121.
- Vosko, L. (2002). The pasts (and futures) of feminist political economy in Canada: Reviving the debate. *Studies in Political Economy*, 68(1), 55-83.
- Waitzkin, H. (1981). The social origins of illness: a neglected history. *International Journal of Health Services*, 11(1), 77-103.
- Warne, G. (2013). Removing civil rights: how dare we. *Mad Matters: A Critical Reader In Canadian Mad Studies* (pp.210-220). Toronto: Canadian Scholars Press Inc.
- Watson, A. C., & Fulambarker, A. J. (2012). The crisis intervention team model of police response to mental health crises: a primer for mental health practitioners. *Best practices in mental health*, 8(2), 1-8.
- Wellin, E., Slesinger, D. P., & Hollister, C. D. (1987). Psychiatric emergency services: evolution, adaptation and proliferation. *Social Science & Medicine*, 24(6), 475-482.
- Whitaker, R. (2010). *Anatomy of an epidemic: Magic bullets, psychiatric drugs, and the astonishing rise of mental illness in America*. New York: Broadway Books.
- White, K. & Pike, R. (2013). *The making and marketing of mental health literacy in Canada in*

- LeFrançois, B., Menzies, R. & Reaume, G. (Eds). *Mad Matters: A critical reader in Canadian Mad Studies* (pp.239-252). Toronto: Canadian Scholars' Press Inc.
- Wiktorowicz, M. (2005). Restructuring mental health policy in Ontario: Deconstructing the evolving welfare state. *Canadian Public Administration*, 48(3), 386-412.
- Wiktorowicz, M., Fleury, M., Adair, C., Lesage, A., Goldner, E., & Peters, S. (2010). Mental health network governance: comparative analysis across Canadian regions. *International Journal of Integrated Care*, 10, 1-14.
- Williams, A. (2012). Emotion work in paramedic practice: The implications for nurse educators. *Nurse Education Today*, 32(4), 368-372.
- Williams, A. (2013). A study of emotion work in student paramedic practice. *Nurse Education Today*, 33(5), 512-517.
- Williams, D., Costa, M., Odunlam & Mohammed, S. (2008). Moving upstream: How interventions that address the social determinants of health can improve health and reduce disparities. *Journal of Public Health Management Practice*, 14(S8), 1-13.
- Wilson-Forsberg, S. & Easley, J. (2012). Chapter 15: Potholes along the roads: The ethics of health research in rural and remote Canada. In J. Kulig & A. Williams (Eds.) *Health in Rural Canada* (pp.280-295). Vancouver: UBC Press.
- Wise-Harris, D., Pauly, D., Kahan, D., Tan de Bibliana, J., Hwang, S., & Stergiopoulos, V. (2016). "Hospital was the only option": Experiences of frequent emergency department users in mental health. *Administration and Policy in Mental Health*, 44(3), 405-412.
- Yin, R. (1999). Enhancing the quality of case studies in health services research. *Health Services Research*, 34(5), 1209-1224.
- Yin, R. (2014). *Case study research: Design and methods*. Los Angeles: Sage.
- Young, A. S., Chinman, M. J., Craddock-O'Leary, J. A., Sullivan, G., Murata, D., Mintz, J., & Koegel, P. (2005). Characteristics of individuals with severe mental illness who use emergency services. *Community Mental Health Journal*, 41(2), 159-168.
- Zola, I. K. (1972). Medicine as an institution of social control. *The sociological review*, 20(4), 487-504.

Appendix A: Informed Consent Form – Interviews

Informed Consent Form

Consent for Interviews

Study name

Paramedics, mental health, and psychosocial care

Researcher

Researcher name: Polly Ford-Jones MA, AEMCA

Doctoral Candidate

Graduate Program in Health

Purpose of the research

Paramedics play a crucial role as a first point of contact with the health and mental health care system for many individuals. They may have a significant impact on an individual already experiencing distress as well as potentially influencing their future interaction with mental health services. Given the unique position of paramedics in their exposure to individuals' living and working conditions, their insights into the factors affecting mental health are invaluable.

While it is clear that paramedics play a role in the chain of mental health and psychosocial care for many, the ways in which this practice is guided and carried out remains unclear, as well as the resources and options for paramedics attempting to manage mental health and psychosocial calls. This study aims to further inform the understanding of mental health equity through exploration of gaps in the health, mental health and social care systems, the living and working conditions of those individuals in distress activating paramedic services, as well as working toward informing equitable management and support for mental health and psychosocial calls.

This study aims to:

- Explore paramedics' understandings of and experiences with mental health and psychosocial calls
- Explore the training and theoretical knowledge in this area, as well as how it is put into practice
- Explore the conditions in which mental health and psychosocial calls take place as well as the working conditions of paramedics managing these calls

- Explore the ways in which mental health calls are managed and resources available for this, as well as the extent to which there are challenges in this area
- Draw on the insights of paramedics through their exposure to individuals' daily living and working conditions, to inform further research and policy around the social determinants of mental health

This study involves several methods of research and aims to involve multiple paramedic services within Ontario. The research will be reported in a doctoral dissertation and may also be presented in other research articles and presentations.

What you will be asked to do in the research

Participants will be asked to participate in an interview, with questions regarding participants' work experience, particularly with regard to mental health and psychosocial care. Interviews are expected to last approximately 30 minutes to an hour. Participants will receive a \$10 Tim Horton's gift card in compensation for their participation in this study.

Risks and discomforts

The risks in this study are anticipated to be low. It is possible the participant may experience some discomfort in discussing past experiences related to their work. Participants are not required to answer any questions they do not wish to, and the interviewer will aim to provide a respectful environment for discussion. Participants may withdraw at any time and may follow up with the researcher with any concerns.

Benefits of the research and benefits to you

The benefits to the participant is their contribution to research on mental health and psychosocial care, further informing training and practice in this area.

Voluntary participation: Your participation in the study is completely voluntary and you may choose to stop participating at any time. Your decision not to volunteer will not influence the relationship you may have with the researchers or study staff or the nature of your relationship with York University either now, or in the future.

Withdrawal from the study: You can stop participating in the study at any time, for any reason, if you so decide. Your decision to stop participating, or to refuse to answer particular questions, will not affect your relationship with the researchers, York University, or any other group associated with this project. In

the event you withdraw from the study, all associated data collected will be immediately destroyed wherever possible.

If you decide to stop participating, you will still be eligible to receive the gift card for agreeing to be in the project.

Confidentiality

Participation in this research will be kept confidential. Reference to comments made by participants will not name an individual or their service or institution. Information gathered in this study will be kept secure and raw data will be accessed only by the researcher and doctoral supervisory committee members. Identifiers of participants will not be stored in the location of the data. Data collected in this study may be used toward completion of a doctoral dissertation, reports, presentations and journal articles. The data will be destroyed by the year 2053. The data will be retained for this period of time for the use in future research and publication.

The participant is welcome to discuss their participation in the study with whomever they wish.

Confidentiality will be provided to the fullest extent possible by law.

Questions about the research?

If you have questions about the research in general or your role in the study, you may contact the researcher or doctoral supervisor at any time. The graduate program office may also be contacted.

This research has been reviewed and approved by the Human Participants Review Sub-Committee, York University's Ethics Review Board and conforms to the standards of the Canadian Tri-Council Research Ethics guidelines. If you have any questions about this process, or about your rights as a participant in the study, you may contact the Senior Manager and Policy Advisor for the Office of Research Ethics.

Legal rights and signatures:

I, _____, consent to participate in the research study, Paramedics, Mental Health and Psychosocial Care conducted by Polly Ford-Jones. I have understood the nature of this project and wish to participate. I am not waiving any of my legal rights by signing this form. My signature below indicates my consent.

Signature _____

Date _____

Participant

Signature _____

Date _____

Principal Investigator

Additional consent:

Additionally, the participant consents to having the interview (sub: focus group) audio-recorded for the purpose of transcription of the data. The participant may ask the interviewer to stop the recording at any time.

Signature Participant: _____

Date: _____

Signature Investigator: _____

Date: _____

Appendix B: Informed Consent Form – Observation

Informed Consent Form

Consent for Observation in a Paramedic Service

Study name

Paramedics, mental health, and psychosocial care

Researcher

Researcher name: Polly Ford-Jones MA, AEMCA

Doctoral Candidate

Graduate Program in Health

Purpose of the research

Paramedics play a crucial role as a first point of contact with the health and mental health care system for many individuals. They may have a significant impact on an individual already experiencing distress as well as potentially influencing their future interaction with mental health services. Given the unique position of paramedics in their exposure to individuals' living and working conditions, their insights into the factors affecting mental health are invaluable.

While it is clear that paramedics play a role in the chain of mental health and psychosocial care for many, the ways in which this practice is guided and carried out remains unclear, as well as the resources and options for paramedics attempting to manage mental health and psychosocial calls. This study aims to further inform the understanding of mental health equity through exploration of gaps in the health, mental health and social care systems, the living and working conditions of those individuals in distress activating paramedic services, as well as working toward informing equitable management and support for mental health and psychosocial calls.

This study aims to:

- Explore paramedics' understandings of and experiences with mental health and psychosocial calls
- Explore the training and theoretical knowledge in this area, as well as how it is put into practice
- Explore the conditions in which mental health and psychosocial calls take place as well as the working conditions of paramedics managing these calls
- Explore the ways in which mental health calls are managed and resources available for this, as well as the extent to which there are challenges in this area

- Draw on the insights of paramedics through their exposure to individuals' daily living and working conditions, to inform further research and policy around the social determinants of mental health

This study involves several methods of research and aims to involve multiple paramedic services within Ontario. The research will be reported in a doctoral dissertation and may also be presented in other research articles and presentations.

What you will be asked to do in the research

Participants will have the researcher present with them for observation while on duty for the duration of their shift (the shift(s) agreed upon by the paramedic service and the paramedic). The researcher will be present and observing as the paramedic goes about their regular shift duties and responds to calls.

Participants will receive a \$10 Tim Horton's gift card in compensation for their participation in this study.

Risks and discomforts

The risks in this study are anticipated to be low.

The researcher will at any time take direction from the paramedic crew or other paramedic services staff with regard to presence and safety on scenes or in the ambulance.

The researcher may take notes about the work environment, circumstances of calls, and resources available to manage calls, however the researcher is not evaluating the performance of individual paramedics.

Given the nature of paramedic work, being called to medical and trauma emergency situations with high demand and low resources, in certain circumstances, it is possible that the paramedic crew might direct the researcher to assist, in the capacity of a bystander trained in first aid. Such circumstance would be entirely at the direction of the paramedic.

Participants may withdraw at any time and may follow up with the researcher with any concerns.

Benefits of the research and benefits to you

The benefits to the participant is their contribution to research on mental health and psychosocial care, further informing training and practice in this area.

Voluntary participation: Your participation in the study is completely voluntary and you may choose to stop participating at any time. Your decision not to volunteer will not influence the relationship you may have with the researchers or study staff or the nature of your relationship with York University either now, or in the future.

Withdrawal from the study: You can stop participating in the study at any time, for any reason, if you so decide. Your decision to stop participating, or to refuse to answer particular questions, will not affect your relationship with the researchers, York University, or any other group associated with this project. In the event you withdraw from the study, all associated data collected will be immediately destroyed wherever possible.

If you decide to stop participating, you will still be eligible to receive the gift card for agreeing to be in the project.

Confidentiality

Participation in this research will be kept confidential. Reference to participants or management of calls will not name a participant or their service or institution.

In order to ensure confidentiality for the recipients of care on calls, no names, dates of birth or addresses from calls will be recorded in field notes or referred to in the analysis in accordance with the Personal Health Information Protection Act (PHIPA) (2004).

Information gathered in this study will be kept secure and raw data will be accessed only by the researcher and doctoral supervisory committee members. Identifiers of participants will not be stored in the location of the data. Data collected in this study may be used toward completion of a doctoral dissertation, reports, presentations and journal articles. The data will be destroyed by the year 2053. The data will be retained for this period of time for the use in future research and publication.

The participant is welcome to discuss their participation in the study with whomever they wish.

Confidentiality will be provided to the fullest extent possible by law.

Questions about the research?

If you have questions about the research in general or your role in the study, you may contact the researcher or doctoral supervisor at any time. The graduate program office may also be contacted.

This research has been reviewed and approved by the Human Participants Review Sub-Committee, York University's Ethics Review Board and conforms to the standards of the Canadian Tri-Council Research Ethics guidelines. If you have any questions about this process, or about your rights as a participant in the study, you may contact the Senior Manager and Policy Advisor for the Office of Research Ethics.

Legal rights and signatures:

I, _____, consent to participate in the research study, Paramedics, Mental Health and Psychosocial Care conducted by Polly Ford-Jones. I have understood the nature of this project and wish to participate. I am not waiving any of my legal rights by signing this form. My signature below indicates my consent.

Signature _____

Date _____

Participant

Signature _____

Date _____

Principal Investigator

Appendix C: E-mail template invitation for interviews with paramedics

Dear *{X region}* Paramedic,

You are invited to participate in an interview. A doctoral candidate from York University is conducting research on mental health and psychosocial care in the prehospital, paramedic services setting and would value your experience in this research. Your participation is completely voluntary, and is in no way required by *{X Region Paramedic Services}*.

Paramedics play a crucial role as a first point of contact with the health and mental health care system for many individuals. Given the unique position of paramedics in their exposure to individuals' living and working conditions, your insights into the factors affecting mental health are invaluable. Your participation will contribute to research surrounding the management of mental health and psychosocial care as well as research around the factors leading to mental health and psychosocial calls for paramedic services.

This study has been approved by the York University Faculty of Graduate Studies Research Ethics Board. The services involved in the study will remain confidential in any written or presented research, and will be identified as for example "a paramedic service in a rural/suburban region of Ontario," and paramedics would be identified only as for example "a paramedic in a rural/suburban region of Ontario."

Every effort will be made to accommodate a time that suits participants to complete an interview. Interviews will be held at a location within the region. A token of a \$10 Tim Horton's gift card will be provided to thank each participant for their time.

Your time and consideration in participating in this research is greatly appreciated. Please do not hesitate to contact me with any further questions or concerns. Please contact the researcher via e-mail if you are interested in participating.

Appendix D: List of People Interviewed

| ID # | Role | Gender | Date |
|-------------|--------------------------------|---------------|------------------|
| 001 | Front-line paramedic Site 1 | Woman | October 3, 2017 |
| 002 | Front-line paramedic Site 1 | Man | October 4, 2017 |
| 003 | Front-line paramedic Site 1 | Man | October 4, 2017 |
| 004 | Front-line paramedic Site 1 | Woman | October 4, 2017 |
| 005 | Front-line paramedic Site 1 | Man | October 6, 2017 |
| 006 | Front-line paramedic Site 1 | Woman | October 17, 2017 |
| 007 | Front-line paramedic Site 1 | Woman | October 19, 2017 |
| 008 | Front-line paramedic Site 2 | Man | January 11, 2018 |
| 009 | Front-line paramedic Site 2 | Man | January 11, 2018 |
| 010 | Front-line paramedic Site 2 | Woman | January 12, 2018 |
| 011 | Front-line paramedic Site 2 | Man | January 12, 2018 |
| 012 | Front-line paramedic Site 2 | Woman | January 25, 2018 |
| 013 | Front-line paramedic Site 2 | Woman | January 25, 2018 |

| | | | |
|-----|--------------------------------|-------|------------------|
| 014 | Front-line paramedic Site 2 | Man | January 25, 2018 |
| 015 | Front-line paramedic Site 2 | Woman | January 25, 2018 |
| 016 | Front-line paramedic Site 2 | Woman | January 26, 2018 |
| 017 | Front-line paramedic Site 2 | Woman | January 26, 2018 |
| 018 | Front-line paramedic Site 3 | Woman | January 30, 2018 |
| 019 | Front-line paramedic Site 3 | Man | January 30, 2018 |
| 020 | Front-line paramedic Site 3 | Woman | February 8, 2018 |
| 021 | Front-line paramedic Site 3 | Man | March 28, 2018 |
| 022 | Front-line paramedic Site 3 | Man | March 28, 2018 |
| 023 | Front-line paramedic Site 3 | Woman | March 28, 2018 |
| 024 | Front-line paramedic Site 3 | Woman | April 4, 2018 |
| 025 | Front-line paramedic Site 3 | Man | April 4, 2018 |
| 026 | Front-line paramedic Site 3 | Woman | April 4, 2018 |
| 027 | Front-line paramedic Site 1 | Man | April 23, 2018 |
| 028 | Front-line paramedic Site 3 | Woman | May 7, 2018 |

| | | | |
|-----|---|-------|------------------|
| 029 | Front-line paramedic Site 3 | Woman | May 7, 2018 |
| 030 | Front-line paramedic Site 1 | Man | May 10, 2018 |
| 031 | Front-line paramedic | Woman | June 21, 2018 |
| 032 | Management, Ontario paramedic service and paramedic educator | Man | January 16, 2018 |
| 033 | Management, Ontario paramedic service | Man | January 28, 2018 |
| 034 | Management, Ontario paramedic service | Woman | April 3, 2018 |
| 035 | Management, Ontario paramedic service | Man | April 13, 2018 |
| 036 | Paramedic educator and front-line paramedic | Man | May 14, 2018 |
| 037 | Paramedic educator and front-line paramedic | Man | May 14, 2018 |
| 038 | Management, Ontario paramedic service | Woman | June 4, 2018 |
| 039 | Paramedic educator | Woman | June 25, 2018 |
| 040 | Paramedic educator and retired front-line paramedic | Woman | June 25, 2018 |
| 041 | Paramedic educator and front-line paramedic | Man | June 27, 2018 |

| | | | |
|-----|---|-------|--------------------|
| 042 | Ontario Base Hospital Physician/Manager | Man | August 14, 2018 |
| 043 | Ontario Base Hospital Physician/Manager | Woman | August 15, 2018 |
| 044 | Ontario Base Hospital Physician/Manager | Man | August 20, 2018 |
| 045 | Ontario Base Hospital Physician/Manager | Man | September 13, 2018 |
| 046 | Ontario Base Hospital Physician/Manager | Woman | October 16, 2018 |

Total: 46 Interviewees

Appendix E: Interview Guides

Semi-structured focus group/interview guide for paramedics

Participants will be provided the consent form prior to beginning the audiotape and interviewing. Participants will be offered time to ask the researcher any questions prior to beginning. It will be reiterated to participants that they may choose not to answer any questions they do not wish to, may stop at any time, and that the interviews are confidential – no names will be used nor will the name of the service or institution. As the interview/focus group is semi-structured, participants will be advised that it is intended to be conversational in nature rather than formal question and answer.

1. Tell me about yourself and your background.
2. What does a typical shift look like for you?
3. Tell me about how your service works.
4. What kinds of calls do you do? Do you feel you do some types more than others?
5. What comes to mind when you hear ‘mental health call.’ ‘Psychosocial call?’
6. Tell me about some of the ways mental health calls are managed by paramedics.
7. What is an example of a call that you’ve done recently that you would describe as a ‘mental health call?’ ‘A psychosocial call?’
8. What makes it easier to manage a mental health call? More difficult?
9. Tell me about what kind of training you have had in managing these calls.
10. Is there other training you wish you had in managing these calls?
11. What is it like interacting with other allied resources or services when managing calls?
12. Are there other resources you wish you had to manage these calls?
13. Describe a time when you had to take someone to the emergency department from a mental health or psychosocial call, but you thought another option would have been better.
14. Instead of going to the emergency department, what other options could there be for paramedics managing mental health and psychosocial calls?

15. When you are on the scene of mental health or psychosocial calls, are there things that you notice are contributing to a person's distress?
16. Of some of these 'psychosocial' factors, what role do you feel paramedics have in managing or addressing them?
17. If you could speak directly to a policymaker, what changes would you recommend that would enhance patient care in this area?
18. Any questions for me?

Semi-structured focus group/interview guide for paramedic services management

1. Tell me about yourself and your **background**.
2. What is your **role** within the service?
3. Tell me about how your **service works**.
4. What different **kinds of calls** paramedics do? Are there some types of calls that seem more frequent than others?
5. What would you describe as a '**mental health call**?' 'A **psychosocial call**?' Can you provide an example?
6. **How often** do paramedics do these types of calls?
7. Tell me about some of the ways mental health calls are **managed by paramedics**.
8. Are there **challenges paramedics face** when managing mental health calls? Anything that makes it **easier** manage them?
9. What kind of **training** do paramedics receive regarding mental health calls?
10. What do you think would **improve the way** that paramedics are able to manage mental health calls?
11. Are there **resources or other supports** that could help paramedics better manage mental health or psychosocial calls?
12. What or **who determines what resources** are available to paramedic services to manage these calls? What are some of the competing priorities?
13. What are some of the **barriers for having these resources** or supports? What could help overcome these barriers?
14. What **other parts** of the **health care system or social services** sector could impact the mental health and psychosocial calls paramedics see?
15. Tell me about a situation where a paramedic has to take someone **to the emergency department** for a mental health or psychosocial call, but you think another option would be better.
16. Instead of going to the emergency department, **what other options could there** be for mental health and psychosocial calls?
17. If you could speak directly to a **policymaker**, what changes would you recommend that would enhance patient care in this area?

18. Any questions for me?

Semi-Structure Interview Guide - Education in Paramedic Services

1. Tell me about yourself and your background.
2. Tell me about your role at the college and in education and your paramedic related experience.

Mental health and Psychosocial Calls

3. How would you **describe a ‘mental health call’** as seen by paramedic services? ‘A psychosocial call?’
4. Tell me about some of the **ways mental health calls** are **managed** by paramedics.
5. What **guidelines** do paramedics have with regard to managing mental health calls?
6. Are there **challenges paramedics face** when managing mental health calls? Anything that makes it **easier** manage them?
7. What **resources** do paramedics have available to them to manage mental health calls?
8. Are there **resources or other supports** that could help paramedics better manage mental health or psychosocial calls? What are barriers to having these resources or supports

Training

11. Tell me about what kind of **training** paramedics have in **managing mental health calls**.
12. Tell me about how this has **changed over the years**.
13. What are some of the **challenges** in training paramedics with regard to managing mental health calls?
14. Is there anything that **would make it easier to train/educate paramedics** with regard to mental health and psychosocial calls?
15. Has the **extent to which paramedics require training/education** in the area of mental health calls **changed** or **remained the same**?
16. Is there **other training you wish** paramedics or paramedic students could have in managing these calls?

Social Determinants

17. What **other parts** of the **health care system or social services** sector could impact the mental health and

psychosocial calls paramedics see?

18. Of some of these 'psychosocial' factors, **what role do you feel paramedics have** in managing or addressing them?

Conclusion

19. If you could speak directly to a **policymaker**, what changes would you recommend that would enhance patient care in this area?

Semi-structured focus group/interview guide for policymakers/base hospital physician

1. Tell me about yourself and your background.
2. Tell me about your role in your organization.
3. What are some current priority issues for paramedic services?
4. How would you describe a 'mental health call' as seen by paramedic services? 'A psychosocial call?'
5. To what extent have mental health or psychosocial calls and paramedic services presented as a priority?
6. What guidelines do paramedics have with regard to managing mental health calls?
7. What resources do paramedics have available to them to manage mental health calls?
8. What determines what funding and resources are available to paramedic services to manage these calls? What are some of the competing priorities?
9. If money and resources were not an issue, what changes would you recommend that would enhance patient care in this area?

Appendix F: Observation shifts

| Site | Shifts | Number of calls | Mental health, substance use or psychosocial call content |
|------|---|-----------------|---|
| 1 | 1 shifts x 12 hours 2 shifts x 8 hours | 12 calls | <p>1 call – self-harm and mental health history</p> <p>1 call – mental health and substance use</p> <p>1 call – mental health</p> <p>1 call – substance use</p> <p>2 calls – potentially relevant mental health history</p> <p>1 calls - medical plus possible mental health element</p> <p>1 call – psychosocial home care needs</p> |
| 2 | 4 shifts x 8hrs | 4 calls | <p>1 call – mental health transfer</p> <p>1 call – mental health related</p> |
| 3 | 3 shifts x 8hrs | 4 calls | <p>1 call – medical plus mental health</p> <p>1 call – medical plus psychosocial factors impacting the call</p> |

Appendix G: E-mail Template for request for college curriculum documents

Dear {Paramedic program coordinator}

I am a doctoral candidate from York University, writing to invite participation from {Name of College} in a research study, 'Paramedics, Mental Health and Psychosocial Care'. The study is aiming to explore the ways in which mental health and psychosocial care are managed in the prehospital, paramedic services setting in Ontario, the experience of paramedics in managing these types of calls, as well as to gain further insights into the factors leading to mental health and psychosocial calls for paramedic services.

Paramedics play a crucial role as a first point of contact with the health and mental health care system for many individuals. They may have a significant impact on an individual already experiencing distress as well as potentially influencing their future interaction with mental health services. Given the unique position of paramedics in their exposure to individuals' living and working conditions, their insights into the factors affecting mental health are invaluable.

This study involves several methods of research and aims to involve multiple paramedic services within Ontario. The research will be reported in a doctoral dissertation and may also be presented in other research articles and presentations. **I am requesting your involvement in this study through the sharing of your paramedic program curriculum documents related to mental health or psychosocial care.**

This study has been approved by the York University Faculty of Graduate Studies Research Ethics Board. As a doctoral candidate I am working with the supervision of three university faculty and the School of Health Policy and Management. The colleges involved in sharing program curricula will remain confidential in any written or presented research, and will be identified as for example "a paramedic program in Ontario." The involvement of your program in sharing these documents is completely voluntary.

Your time and consideration in participating in this research is greatly appreciated. Please do not hesitate to contact me with any further questions or concerns. I look forward to your response.

Sincerely,

Polly Ford-Jones MA, AEMCA
PhD Candidate
Health Policy and Equity
York University

Appendix H: Codes

| Name | Description |
|--|---|
| Call management | Refers to how paramedics manage situations or provide care on mental health or psychosocial calls. Code broadly for this if participant describes situations or experiences with call management, including resources, skills and feelings about managing these calls. |
| Communication, relating, empathy | Refers to ways in which calls are managed with regard to communication approaches, for interacting with patients and empathy for patients. Code for this if participant describes these in relation to call management. |
| Prioritization of mental health (vs physical health calls) in managing calls | Refers to how the management of mental health or psychosocial calls is prioritized compared to calls for physical health needs in paramedic services. Code for this when participant describes perceptions of how management of mental health calls is prioritized. |
| Skills for call management | Refers to any skills paramedics may use to manage mental health or psychosocial calls. Code for this when participants discuss any skills that are either helpful, unhelpful or are generally used for managing mental health or psychosocial calls. |
| Call Types | Refers to descriptions of the types of calls paramedics attend to. Code for this if participant describes any types of calls paramedics attend to, and also if participant describes different types of mental health or psychosocial calls. |
| Care conditions | Refers to any context or circumstances in which paramedics provide care, for example descriptions of the types of places in which different calls take. Code for this if participant describes any such context or circumstances or describes what it is like providing care in different settings. |
| Challenges in front line work | Refers broadly to any challenges encountered by paramedics in their work, in particular when managing mental health or psychosocial calls. Code for this when participant refers to any challenges related to the work they do and providing care on the front lines. |
| Helplessness, frustration | Refers to paramedics describing feeling helpless or frustration when managing calls. Code for this when participant describes situations or experiences where paramedics feel helpless or frustrated managing certain calls. |
| Lack of information | Refers to paramedics having limited information when attending to calls, both prior to arriving at a scene as well as on scene. Code for this when participant describes situations or experiences where paramedics have limited or not enough information when managing mental health or psychosocial calls. |
| Defining mental health calls | Refers to any description of what is a mental health call. Code for this when a participant describes a mental health call. |
| Mental health call volume | Refers to any description of how often paramedics attend to mental health or psychosocial calls. Code for this when a participant |

| Name | Description |
|--|---|
| | describes the frequency of paramedics attending to mental health or psychosocial calls. |
| Youth, pediatric mental health | Refers to any situation or experience regarding youth or pediatric mental health, for example paramedics attending to mental health calls for pediatric patients or descriptions of mental health needs of youth in the community. Code for this when a participant describes any situation and refers to pediatric or youth mental health. |
| Education, training | Refers to the education or training of paramedics, in particular education or training for mental health or psychosocial calls. Code for this when a participant describes the education or training received or not received by paramedics at any level ie: paramedic students in college, paramedic service training or Base Hospital training. |
| Hospital, ED | Refers broadly to care received in the hospital ED. Code for this when participant discusses any situation or experience taking place at the hospital ED. |
| Outcomes | Refers to what happens to patients after paramedics transport them to the ED. Code for this when a participant refers to situations, experiences or questions about what happens to patients with mental health and psychosocial needs after paramedics transfer care to the ED. |
| Priority of mental health (vs physical health) in the ED | Refers to the prioritization of patients with mental health needs in the ED. Code for this when participants discuss situation, experiences or perceptions about how patients with mental health needs are prioritized in the ED. |
| Transfers | Refers to transfers of patients by paramedics from one hospital ED to another hospital, often referred to in more rural settings. Code for this when participant describes situations or experiences with transferring patients from one hospital to another. |
| Organizational working conditions and management | Refers to the organizational working conditions and experiences with management and leadership in paramedic services. Code for this when participant describes organizational structure of paramedic services or describe experiences with organizational working conditions and management. |
| Medicating and mental health | Refers to medication/pharmacological intervention for mental health needs. This may refer to paramedics' ability to administer medication such as sedation for mental health calls, or other reference to individuals with mental needs and use of prescribed psychotropic medications. Code for this when participant makes any reference to individuals with mental health needs and the use of psychotropic medications. |
| Memorable Quotes | Refers to any quote that the coder feels is particularly striking and is worth highlighting. Code for this for any quote the coder feels is memorable and will warrant further exploration or use. |
| Mental Health - community services | Refers to any community mental health services. This may include use of services, lack of services, need for services or any other reference to community mental health services that are not specifically hospital ED services. Code for this when participant describes any situation or |

| Name | Description |
|---------------------------------------|---|
| | experience involving community mental health services. |
| Navigating the system | Refers to experiences of navigating community mental health services. Code for this when participant refers to situations or experiences involving navigation of community mental health services, ie: being aware services exist, accessing services, ability to use required services. |
| Service gaps (time etc.) | Refers to experiences of gaps in community mental health services, such as accessibility dependent on geography, availability (ie: hours of the day and days of the week), services that do not exist or are not available. Code for this when participant describes any community mental health service needs not being met. |
| Silos | Refers to any disconnect or “siloing” of different mental health and social services. Code for this when participant describes disconnect and lack of cohesion or integration between health care, mental health care or other social services. |
| Observing experience - methods | Refers to situations or experiences regarding observation in paramedic services documented in field notes. Code for this in field notes where the researcher has documented situations or experiences related to carrying out observations in paramedic services. |
| Paramedic mental health | Refers to paramedics’ own mental health needs. Code for this when participant describes any situations, experiences or perceptions of paramedic’s own mental health needs. |
| Burnout | Refers to paramedic burn out or stress related to ongoing care provision and ongoing work with in paramedic services. Code for this when participant describes paramedics being “burnt out.” |
| Personal experience | Refers to personal experiences that paramedics have related to mental health. This may include paramedics’ own mental health challenges related to work, or any experience outside of work related either to their own mental health or that of someone close to them. |
| Paramedic role | Refers to descriptions of what a paramedic’s role is in the work they do. Code for this when participant describes perceptions of what a paramedic’s role is or should be. |
| Paramedics’ decision making - choices | Refers to paramedic’s decision making on calls, in particular mental health or psychosocial calls. Code for this when participant describes any situation or experience relating the choices paramedics make, or the decision making of paramedics on mental health or psychosocial calls. |
| Policy, legislation | Refers to any policy or legislation that may guide or impact the ways in which paramedics provide care or the situation of individuals with mental health needs. Code for this when participant discusses any type of policy or legislation. |
| Consent | Refers to issues around consent for care or consent for sharing personal health information between service providers. Code for this when participant describes situations or experiences relating to patient consent. |

| Name | Description |
|------------------------------|--|
| Deinstitutionalization | Refers to any situation, experience or perceptions relating to the process or results of deinstitutionalization. Code for this when participant refers to deinstitutionalization or generally refers to patients being moved into the community from mental health hospitals or institutions. |
| Professional designation | Refers to paramedics receiving the designation of “profession,” a status that they do not currently hold in Ontario. Code for this when participant discusses any issues or situations relating to the professionalization of paramedics. |
| Prevention | Refers to preventative care or services for mental health. Code for this when situations or experiences of preventative care or a need for preventative care are described. |
| Psychosocial | Refers to any calls or call types paramedics receive that are related to social needs. These may or may not refer specifically to mental health needs but involve social needs that paramedics encounter with patients. Code for this when participant describes a situation or experience related to broader social needs of individuals paramedics encounter on calls. |
| Low acuity calls | Refers to low priority or acuity calls to paramedics not requiring rapid, emergency response. Low acuity is a term commonly used in paramedic services. Code for this when participant refers to “low acuity” calls. |
| Social isolation, loneliness | Refers to situations or experiences of individuals who are isolated or lonely within their community or circumstances. Code for this when participant refers to individuals experiencing isolation or loneliness. |
| Recommendations | Refers to recommendations relating to paramedics attending to mental health or psychosocial calls. These may be related to training and education, resources available, organizational structure or other recommendations outside of paramedic services. Code for this when participant makes recommendations related to mental health needs and care provision, including recommendations for paramedic services. |
| Resources, allied resources | Refers to resources, including allied resources (police and fire) or other programmatic resources (including nurses or social workers) that paramedics encounter on calls or may be required on calls. Code for this when participant refers to situations or experiences with resources including when they are or are not required and whether or not they are or are not available. |
| Rural | Refers to any situations or experiences for paramedic services in rural geography. Code broadly for any situations or experiences involving rural geography. |
| Social determinants | Refers to any situation or experience where a social determinant of health is discussed, for example any non-medical factor described as relevant for an individual’s physical or mental health. Code broadly for any non-medically focused factors related to physical or mental health outcomes. |
| Race, gender | Refers to situations or experiences with race or gender (broadly) |

| Name | Description |
|----------------------|--|
| | impacting physical or mental health and/or care provision. Code for any situations referring to race or gender. |
| Service access | Refers to issues around service access for physical or mental health needs, impacting physical or mental health outcomes. Code for any issues referring to service accessibility. |
| Specific programming | Refers to mental health or psychosocial programming in paramedic services. Code for this when participant describes programs that exist for prehospital management of mental health or psychosocial calls, or that participants would like to have. |
| System Pressures | Refers broadly to pressures in the paramedic or health system impacting care paramedics are able to provide on mental health or psychosocial calls. Code for this when participant refers to pressures experienced in different parts of the paramedic or health system. |
| Transitions in care | Refers to transitions in care from paramedic services to other services. Code for this when participant discusses situations or experiences relating to transitions from paramedic care to other services (ie: hospital care). |
| Violence, safety | Refers to any situation, experience or training related to violence and safety for paramedics providing care. Code for this when there is any discussion of issues around safety, violence or preventative measures to manage safety or violence on mental health or psychosocial calls. |