ENDING VIOLENCE
Association of BC

# Community-Based Anti-Violence Worker Wellness: A Review of the Literature and Recommendations for the Office of the Federal Ombudsman for Victims of Crime

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April 2020

## Abstract

Community-based anti-violence and victim services workers are routinely exposed to trauma, which puts them at risk of work-related stress such as post-traumatic stress injuries, vicarious trauma, and secondary traumatic stress. Yet, these workers often lack access to adequate wages and benefits, workplace supports, post-trauma related workplace injury supports, and training opportunities to build resilience to the impacts of this work, especially when compared to system-based first responders, such as police, firefighters, and paramedics. This review of the academic and grey literature on community-based anti-violence worker wellness, published between January 2010 and January 2020, reveals significant disparities in the research on community-based and system-based helping professionals, as well as disparate strategies in place to prevent and address the negative impacts of trauma work. The paper concludes with recommendations for the Office of the Federal Ombudsman for Victims of Crime.

## Keywords

Worker wellness, vicarious trauma, secondary traumatic stress, compassion fatigue, anti-violence workers, victim services, first responders, workplace supports.

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## 1. Overview of the Issue

Community-based anti-violence and victim services workers (herein referred to as community-based anti-violence workers) provide crucial supports to victims of gender-based violence and are routinely exposed to trauma, which puts them at risk of work-related stress such as post-traumatic stress injuries, vicarious trauma, and secondary traumatic stress. Yet, these workers often lack access to adequate wages and benefits, workplace supports, post-trauma related workplace injury supports, and training opportunities necessary to build resilience to the impacts of this work, especially when compared to system-based first responders, such as police, firefighters, and paramedics. The purpose of this paper is to review the current literature on the impacts of responding to violence and trauma for community-based anti-violence workers; explore how work-related stress, such as post-traumatic stress injuries, vicarious trauma, and secondary traumatic stress are addressed in comparison to system-based first responders, such as police, firefighters, and paramedics; and discuss how best to move forward and support community-based anti-violence worker wellness.

Community-based anti-violence workers support and advocate for victims of the most violent crimes, including those impacted by sexual violence, domestic violence, child sexual abuse, and sexual and criminal harassment. Most community-based anti-violence workers provide emergency response and are often the first point of contact made by victims after experiencing violence. Community-based anti-violence workers provide support, and accompaniment for victims to police interviews, hospital exams, and throughout the criminal and family justice systems. These workers also specialize in providing trauma-informed psychological support, assistance for victims dealing with the justice, social service, child protection, housing, and/or health care system, practical help and counselling, and assistance to victims in navigating many complex systems. For example, workers provide information about violence and its impacts, the law, criminal and family justice systems, victims' rights and options, and the status of victims' cases; support victims' decisions; assist victims to develop coping strategies, communicate with authorities (e.g., medical, legal, child protection), and complete applications and forms (e.g., protection orders, Victim Impact Statements, applications for financial compensation); accompany victims to appointments and hearings (e.g., medical, criminal and family court, immigration, parole); work with victims to identify risk factors and develop safety plans for themselves and their children and families; help victims prepare to testify in court and develop strategies for dealing with media, particularly in high-profile cases; support victims to find employment and safe, affordable housing; provide counselling; and refer clients to other community services, including mental health services, legal services, and culturally-specific programs.

System-based first responders, also known as public safety personnel and emergency service personnel (Paterson, Whittle & Kemp, 2015), include police, firefighters, and paramedics. They respond to a wide range of emergencies, including crime, violence, sudden deaths, motor vehicle accidents, and medical emergencies, and are also "regularly exposed to potentially traumatic events, some of which are highlighted as critical incidents" (Carleton et al., 2018). System-based first responders are usually the first on scene following a traumatic incident, and the first to attend to the needs of victims (Greinacher, Derezza-Greeven, Herzog & Nikendei, 2019).

In considering the impacts of exposure to violence and trauma, it is important to recognize how the breadth of work contributes to impacts; while system-based first responders respond to a wide range of calls, some of which involve exposure to violence and trauma, community-based anti-violence workers' singular focus on working with victims of gender-based violence means these workers are consistently exposed to violence and trauma. Additionally, while system-based first responders typically interact with victims of crime only once or on a few occasions in response to an immediate emergency, community-based anti-violence workers often support clients over a longer period of time, thereby developing relationships with them and engaging with their trauma on a deeper level.

The workforces of community-based anti-violence organizations and of system-based first responders are gendered, and it is evident that support for workers exposed to violence and trauma is thus a gender equality issue. While there are more women and non-binary system-based first responders than there have been in the past, these first responder workforces remain male-dominated occupations: women comprise only 4% of firefighters (see Statistics Canada, 2016), 22% of police officers (Conor, Robson, & Marcellus, 2019), and 35% of paramedics (Fischer & MacPhee, 2017). The gendered nature of this work is reflected not only in the workplace culture of first responders, but also in public perceptions. First responders' work is associated with traditionally masculine language such as 'strong,' 'brave,' and 'heroic.' In contrast, community-based anti-violence work is overwhelmingly female-dominated. Rather than their work with victims of violence being seen as 'heroic', female-dominated community-based anti-violence work is framed in traditionally feminine terms, often as an extension of a maternal caring role; it is viewed as a 'helping' profession defined by sympathy, compassion, and interpersonal connection.

The role of first responders in society is highly valued. In contrast, although anti-violence workers play a crucial role in the community, their work remains undervalued; there is a lack of emphasis on the skills and knowledge necessary for community-based anti-violence workers to do their work well, as well as minimization of the impacts of working with victims of violent crime on an ongoing basis. This differential social valuing is revealed by disparate salaries, as well – reflecting Canada's gender wage gap where

women earn $0.87 for every dollar earned by men (Pelletier, Patterson & Moyser, 2019). **In considering the impacts of exposure to violence and trauma, this valuing of 'heroes' (first responders) over 'helpers' (anti-violence workers) is evident in the lack of equitable occupational health and safety supports for preventing and responding to work-related stress, such as post-traumatic stress injuries, vicarious trauma, and secondary traumatic stress.**

Very little statistical data exist on community-based anti-violence workers in Canada, particularly those providing crisis intervention, outreach, and counselling services. Due to inadequate funding and the 24/7 demands of their work, many community-based anti-violence workers are part-time workers, and some organizations also rely on volunteers for overnight crisis line work (Rossiter, Yercich & Jackson, 2014); within this context, community-based anti-violence workers are not equipped to meet the needs of all victims of gender-based violence. Across the community-based anti-violence sector, wages are low, extended health benefits are minimal or non-existent, and pensions are rare or long overdue (Rossiter et al., 2014). Community-based anti-violence workers receive little in the way of formal training due to funding constraints (Logan & Walker, 2018; Rossiter et al., 2014).

In contrast, operating expenditures for police in Canada have increased over the past 20 years, reaching $15.1 billion in 2017/18, with salaries, wages, and benefits accounting for 82% of this total amount, or $12.5 billion (Conor, Robson, & Marcellus, 2019). At the same time, the overall number of police officers in Canada has decreased (despite increases in at least one quarter of municipalities with stand-alone police services or served by RCMP, particularly in British Columbia); women make up only 22% of police officers and only 8% of police officers identify as belonging to a visible minority group, with 4% identifying as Indigenous (Conor et al., 2019). The average salary for a police officer in Canada is over $99,000, and part-time positions are very rare (Conor et al., 2019). According to Statistics Canada, "a challenge for modern policing is the 24/7 demands of police work" (Conor et al., 2019, p. 14), especially given younger police officers' desire for greater work-life balance. Within police services there is also greater recognition of the need to provide support and accommodations to address the "physical and mental hazards" and "high stress environment" of police work (Conor et al., 2019, p. 14).

Data on fire service expenditures in Canada is much more limited than data on policing expenditures (Lamman, Palacios, & Ren, 2015). One report noted that municipalities across Canada continue to increase spending on emergency services, such as police and firefighters (Lamman et al., 2015). The number of firefighters in Canada rose 25% between 1997 and 2012. Between 2000 and 2002, non-fire related calls, such as medical and motor vehicle incidents, increased, while fire-related calls decreased; some research suggests that less than 10% of calls for fire services are for fires (Lamman et al., 2015).

Census data from 2016 indicate that the average wages, salaries, and commissions for firefighters is over $90,000, well above the salary for employees in other public sector occupations (Braedley, 2009; Lamman et al., 2015; Statistics Canada, 2019).

Relatively little is known about paramedics in Canada, including their physical and mental health (Fischer & MacPhee, 2017). Approximately 65% of paramedics are male, and 78% are employed full-time (Fischer & MacPhee, 2017). Among paramedics in Canada, 77% work required overtime (for example, due to shift overrun), 31% work voluntary overtime, and 20% work additional hours on-call or stand-by (Fischer & MacPhee, 2017).

Below, we define key concepts, our research approach, and the framing of trauma exposure and impacts within the literature reviewed. We then report on our findings from the academic and grey literature on risk factors and protective factors for vicarious trauma; the impacts of vicarious trauma; strategies for preventing vicarious trauma and enhancing worker wellness; and disparate prevention strategies and workplace supports available to community-based and system-based workers, including through federal initiatives in Canada. Finally, we offer recommendations for how the Office of the Federal Ombudsman for Victims of Crime can contribute to addressing these discrepancies and enhancing the wellness of community-based anti-violence workers.

### 1.1. Defining Key Concepts

There is an extensive body of literature on the negative impacts of working with victims of violence and trauma. These impacts have been variously described as vicarious trauma, secondary traumatic stress, compassion fatigue, post-traumatic stress injuries, and burnout. However, the terms are often conflated and, as Branson (2019) has noted, “what to call the phenomena of clinicians being physically, cognitive[ly], emotionally, mentally, socially, and/or spiritually affected by bearing witness to other’s [sic] trauma is a source of perplexity” (p. 2).

***Vicarious trauma***, a term coined by McCann and Pearlman (1990), refers to the negative, cumulative impacts of exposure to clients’ disclosures of trauma among clinicians and other helping professionals who develop relationships with their clients (Branson, 2019). Vicarious trauma leads to affective and cognitive changes, including changes in self-esteem, sense of safety, and worldview (Cummings, Singer, Hisaka & Benuto, 2018). Signs and symptoms include intrusive thoughts, nightmares, social isolation, cynicism, and health conditions (Branson, 2019). Vicarious trauma also has an impact on maintaining healthy professional boundaries, decision-making, absenteeism, retention, and the quality of services provided to victims (Branson, 2019; Klinic Community Health Centre, 2013). Vicarious trauma is considered by many to be inevitable, and as such, “should be considered a hazard of the work and a catalyst for

prevention development, training initiatives, and supports for practitioners" (Branson, 2019, p. 3).

***Secondary traumatic stress***, a term coined by Figley (1995), refers to the psychological overwhelm of professionals who respond to trauma, particularly those who do not typically develop an ongoing relationship with those affected (Branson, 2019). This phenomenon is thus more common among first responders, including police, legal professionals, correctional staff, and health care workers. Symptoms of secondary traumatic stress mirror those of Posttraumatic Stress Disorder, including intrusion, avoidance, and hyperarousal (Branson, 2019). Unlike vicarious trauma, which develops over time, secondary traumatic stress is more acute, and can be experienced following a traumatic incident (Branson, 2019; Cummings et al., 2018).

***Compassion fatigue*** is a related concept that describes the sense of helplessness that can be experienced by family, friends, professionals, and communities in the face of trauma; for example, when there are inadequate resources available to meet the needs of trauma survivors (Branson, 2019). ***Burnout*** develops over time; however, unlike vicarious trauma, which results from exposure to trauma, burnout results from poor working conditions, including low wages, poor morale, lack of organizational support and appreciation, and high turnover (Branson, 2019). Burnout can be described as emotional, physical, psychological, and spiritual exhaustion, and it impacts workers' sense of accomplishment (Cummings et al., 2018). Unlike vicarious trauma and secondary traumatic stress, burnout can be experienced by people in many fields and is not specific to working with victims of crime, violence, and trauma (Cummings et al., 2018); however, secondary traumatic stress has been found to be correlated with burnout among system-based first responders (Greinacher et al., 2019). Burnout can also be addressed more easily than vicarious trauma, through changes in roles and responsibilities, staffing, and workload, as well as time off from work (Branson, 2019).

Despite important differences in these concepts, research suggests that the negative impacts of trauma work often co-occur among helping professionals, such as community-based anti-violence workers (Cummings et al., 2018). Anti-violence workers may also have experienced trauma similar to their clients', whether as a result their own experiences of similar types of violence (e.g., domestic violence, sexual violence) or collective trauma (e.g., community disaster, intergenerational trauma) (Tosone, McTighe & Bauwens, 2012).

There is also a growing body of literature on the positive impacts of working with victims of violence and trauma. These positive effects are variously described in the literature as vicarious resilience, post-traumatic growth, and compassion satisfaction. ***Compassion satisfaction***, or the sense of satisfaction associated with helping others, has been found

to be a protective factor against the negative impacts of vicarious trauma, secondary traumatic stress, and burnout (Cummings et al., 2018). Additionally, research is emerging on the subject of trauma-informed practice and its application both to services provided to victims of trauma, and to anti-violence organizations and workers themselves. Several resources are now being developed to support trauma-informed organizations and leadership (see Ending Violence Association of BC, 2019).

## 2. Research Approach and Parameters

The literature review, best described as a narrative literature review, followed the process outlined by Green and colleagues (2006). We included both academic literature and grey literature in the review, to ensure that we captured the latest research, community-based reports, government papers, and handbooks articulating the risk and protective factors, impacts, and prevention strategies for addressing vicarious trauma and secondary traumatic stress among community-based anti-violence workers, in comparison with first responders, such as police, firefighters, and paramedics.

### 2.1. Academic Literature Review

A preliminary search was conducted using Simon Fraser University's Library Search function and Google Scholar with the keyword 'vicarious trauma' combined first with 'victim services' (resulting in 211 hits) and then with 'first responders' (resulting in 1,146 hits). This search was useful in refining and selecting keywords for the academic literature search. Two recent articles on community-based anti-violence workers and first responders (Benuto, Singer, Gonzalez, Newland & Hooft, 2019; Greinacher et al., 2019) were identified during this preliminary search, but did not appear in the academic literature search that followed.

To complete the academic literature search, the first author (K. Rossiter) searched several academic databases (Criminal Justice Abstracts, PsyArticles, ProQuest Sociology Collection, Social Sciences Full Text, and CINAHL Complete) using all combinations of selected keywords relevant to the issues/impacts (wellness, vicarious trauma, secondary traumatic stress, post-traumatic stress, burnout) and groups/sectors (anti-violence, victim services, victim advocates, crisis workers, first responders, police, firefighters, paramedics) from January 2010 to January 2020. Articles were selected based on their relevance to the objective of the research paper, especially those addressing strategies and supports for preventing and responding to vicarious trauma, secondary traumatic stress, post-traumatic stress injuries, and burnout. All articles selected for inclusion in the literature review were written in English and priority was given to articles focused on community-based anti-violence workers and system-based first responders in Canada and the United States.

The academic literature search resulted in 3,707 hits, 108 of which were relevant to the research paper and selected for review. The references of two recent and relevant articles identified in the academic literature search (Wachter, Schrag & Wood, 2020; Wood, Wachter, Rhodes & Wang, 2019) were also manually reviewed, and an additional 11 articles were identified for inclusion in the literature review, bringing the total to 121 academic articles. All of the research articles on community-based anti-violence workers and first responders that were selected for review were annotated by the fourth author (X. Hanson Pastran). Articles specific to only one sector or profession, such as police, firefighters, and paramedics, were reviewed with a focus on prevention strategies and workplace supports to address secondary traumatic stress and post-traumatic stress injuries, for comparison with prevention strategies and workplace supports identified in the literature on community-based anti-violence workers.

Research focused on 911 dispatchers, police-based victim services workers, child protection workers, jurors, correctional and probation officers, lawyers, military personnel, disaster relief workers, health care providers (nurses, physicians, Sexual Assault Nurse Examiners, counsellors), and other caring professionals was excluded, with a few exceptions where the research offered suggestions for innovative strategies and supports that might be considered to address vicarious trauma among community-based anti-violence workers.

The academic literature search revealed a significant gap in research on vicarious trauma, secondary traumatic stress, post-traumatic stress injuries, and burnout in the community-based anti-violence sector, compared to system-based first responders, such as public safety and criminal justice system personnel. The vast majority (94%) of the literature search results focused on system-based first responders (e.g., police, firefighters, paramedics), with only 6% focused on community-based anti-violence workers. An analysis of specific system-based first responders revealed a further disparity in research, with a far more extensive body of literature focused on police (69%) than on first responders more generally (10%), firefighters (9%), and paramedics (6%). This finding reflects observations from Cummings and colleagues (2018) that, despite research on vicarious trauma and secondary traumatic stress in a number of fields, “researchers have neglected to examine these psychological responses in victim advocates” (p. 5).

### 2.2. Grey Literature Review

To complete the grey literature search, the second author (M. Dhillon) conducted a Google search with an advanced search for PDF files so as to focus the search results on community-based research reports, government papers, and toolkits, rather than web-based content. The Google search was completed using all combinations of selected

keywords relevant to issues and impacts (vicarious trauma, compassion fatigue, wellness, post-traumatic stress, secondary traumatic stress, and burnout) and groups/sectors (anti-violence, victim services, first responders, police, firefighters, and paramedics). This search encompassed PDF documents published online between January 2010 and January 2020.

The grey literature documents selected for review were those with an explicit focus on the impacts of trauma (including vicarious trauma), with priority given to documents addressing community-based anti-violence workers in the Canadian context. Additionally, as there is a dearth of recent federal government work focused on anti-violence workers' wellness, a small number of key documents outside of the stated timeframe were also reviewed to inform and contextualize the current discussion; these include Health Canada's 'Guidebook on Vicarious Trauma: Recommended Solutions for Anti-Violence Workers' (Richardson, 2001) and the Department of Justice Canada's 'Working with Victims of Crime: A Manual Applying Research to Clinical Practice' (Hill, 2009). Given its direct relevance, Bill C-211: Federal Framework on Post-Traumatic Stress Disorder Act (Minister of Justice Canada, 2018) was also reviewed. Academic research (e.g., articles in peer-reviewed journals, theses, and dissertations) was excluded from the grey literature search and review, as relevant research articles would have been captured in the extensive academic literature review conducted for this research paper. The literature review below includes findings from both the academic and grey literature.

## 3. Framing of Trauma Exposure and Impacts

The literature, and especially the grey literature, frames trauma exposure differently for system-based first responders and community-based anti-violence workers. For system-based first responders, trauma exposure is often described as 'first hand' or 'primary' trauma, whereas trauma exposure among community-based anti-violence workers is more often framed as 'secondary' or 'vicarious.' This different framing suggests that trauma exposure among system-based first responders is more acute and therefore more serious, which minimizes the real and serious impacts of the work of the community-based anti-violence sector.

It is important to contextualize this terminology as well, recognizing that male-dominated work cultures – such as first responder work – traditionally equate a need for support, or accessing support, with weakness. Reflecting this, the terminology that is used in the grey literature on system-based first responders frequently works simultaneously to diminish stigma and emphasize the importance of prevention and response. In fact, the term 'Occupational Stress Injury (OSI)', used in many federal initiatives addressing the issue in public safety personnel, was developed as "a way to give 'mental injuries' the same legitimacy as physical injuries and thereby help to reduce [the] stigma associated with

mental health problems" (Day & Olsen, 2015, as cited in Oliphant, 2016, p. 7). While the term Post-Traumatic Stress Disorder (PTSD) is also often utilized, a recent Canadian Ministerial Roundtable on Post-traumatic Stress Disorder in Public Safety Officers critiqued the term PTSD as "[contributing] to the negative stigma" (as cited in Oliphant, 2016, p. 10). The framing of prevention and response strategies for police, firefighters, and paramedics similarly works to address this stigma. In an investigation of Occupational Stress Injuries experienced by Toronto Paramedic Services workers, the City of Toronto Ombudsman explicitly stated the goal of 'making the strong stronger' (Crean, 2015). For first responders and public safety personnel, addressing trauma impacts is frequently discussed as part of a larger health strategy (e.g., as part of 'behavioural health'), further legitimizing these impacts as occupational health issues.

Of the potentially traumatic exposures faced by Canadian public safety personnel (e.g., police, firefighters, paramedics, dispatchers, correctional workers), sudden violent death is identified as the most distressing, and a potential critical incident (Carleton et al., 2019). Yet, whereas system-based first responders and public safety personnel are more likely to "see a range of individuals and situations over a given shift, not all of which would be identified as traumatic" (Richardson, 2001, p. 55), community-based anti-violence workers are exposed to serious trauma on a daily basis. Community-based anti-violence workers do not only bear witness to victims' trauma by hearing about their experiences, but many also witness this trauma first-hand when they provide support to victims in the immediate aftermath of violence as they navigate hospitals, police departments, and transition houses (Richardson, 2001). Within the community-based anti-violence sector, the long-term impacts of the work are well understood: "It's not 'if' but 'when' and 'how' we will be affected by our exposure to our client's trauma" (Klinic Community Health Centre, 2013, p. 123). It is therefore critical to recognize that community-based anti-violence workers across Canada are exposed to trauma in similar ways to first responders, and equally deserving of investments in occupational health and safety supports.

## 4. Risk and Protective Factors for Vicarious Trauma

While not all people exposed to work-related stress and trauma will experience work-related stress injuries and/or vicarious trauma, the risk factors for these negative outcomes are fairly consistent across the literature. According to Cummings and colleagues (2018), community-based anti-violence workers are generally at high risk of vicarious trauma, secondary traumatic stress, and burnout due to regular exposure to disclosures of violent crime from highly traumatized victims, long hours, and limited workplace supports. However, there are also many factors that protect against these negative impacts of working with victims of crime and trauma.

## 4.1. Risk Factors

Women (both community-based anti-violence workers and system-based first responders) are at a higher risk than men of experiencing work-related stress injuries, such as secondary traumatic stress (Benuto et al., 2019; Choi, 2011; Greinacher et al., 2019). This is notable given that most community-based anti-violence workers are women, while system-based first responder work remains male-dominated. Based on national data, we know that, compared with men, women in Canada experience higher rates of sexual violence, criminal harassment, and severe and lethal intimate partner violence, as well as more injuries related to intimate partner violence (Perreault, 2015; Burczycka, 2016). Reflecting this reality, many community-based anti-violence workers – most of whom are women – are therefore more likely to have been impacted by violence and trauma in their lives. In fact, for many it is these experiences that have led them to working in the anti-violence sector. In one Canadian study, close to 97% of transition house workers in remote, northern BC communities had themselves experienced trauma (Bishop & Schmidt, 2011). This is important to consider, given that community-based anti-violence workers with a personal history of victimization and trauma are at increased risk of experiencing vicarious trauma, with the risk dependent on the severity and types of trauma experienced (Bishop & Schmidt, 2011; Choi, 2011; Dworkin et al., 2016; Killian, 2008; Klinic Community Health Centre, 2013; Wood et al., 2017).

Research suggests that younger workers with less experience are at greater risk of experiencing negative outcomes as a result of working with trauma victims (Dworkin, Sorell & Allen, 2014; Klinic Community Health Centre, 2013; Wood et al., 2017). Yet, longer tenure in the field has also been associated with increased risk of vicarious trauma and compassion fatigue (Cummings et al., 2018; Klinic Community Health Centre, 2013; McKim & Smith-Adcock, 2014). While there is a high level of awareness in community-based anti-violence workforces about the risk of post-traumatic stress injuries and vicarious trauma, the impacts of the work may depend in part on individual level risk factors. For example, lower levels of self-awareness, or inability to recognize the signs and symptoms of vicarious trauma, and lower use of coping skills, may increase the risk of negative impacts (Killian, 2008; Wood et al., 2017). Unhealthy coping skills, such as denial and avoidance, lower resiliency, and higher cynicism are also associated with increased work stress and other negative psychological outcomes (Killian, 2008; Kulkarni, Bell, Hartman & Herman-Smith, 2013; Wood et al., 2017). Finally, social isolation can also contribute to negative outcomes (Killian, 2008), which underscores the importance of social connection and support to mitigate this risk.

While the above risk factors relate to the identities and experiences of workers themselves, work-related risk factors are also important to consider. For example, higher client caseloads, and greater number of hours of direct work with victims, is associated

with greater risk of vicarious trauma and burnout (Benuto et al., 2019; Dworkin et al., 2016; Killian, 2008; Klinic Community Health Centre, 2013; McKim & Smith-Adcock, 2014). One report (Wood et al., 2017) indicated that the risk of secondary traumatic stress was higher among those for whom more than 40% of their work time was spent providing direct service to victims of violence, while another (McKim & Smith-Adcock, 2014) indicated that exposure to clients with more serious trauma experiences was associated with increased risk of compassion fatigue. Overwork and unmanageable workloads that make it impossible to complete their work in the time available also contribute to negative outcomes for community-based anti-violence workers (Klinic Community Health Centre, 2013; Kulkarni et al., 2013; Wood et al., 2017).

Work mismatches, such as a poor fit between a particular person and their organization or position, can also lead to negative outcomes (Kulkarni et al., 2013; Wood et al., 2017). Lack of resources for victims and survivors, and difficulties in connecting victims and survivors to needed resources (e.g., counselling), also generate feelings of frustration and powerlessness, which have a negative impact on community-based anti-violence workers (Merchant & Whiting, 2015). Supporting victims and survivors who return to abusive partners can also take a toll on workers, who may feel helpless, hopeless, or that they have failed to provide needed support to their clients (Fusco, 2013; Merchant & Whiting, 2015).

The work environment plays an important role in the risk of negative outcomes in trauma work. In particular, lack of perceived emotional support from colleagues and supervisors, infrequent or poor quality supervision contribute to negative outcomes (Babin, Palazzolo & Rivera, 2012; Dworkin et al., 2016; Killian, 2008). The likelihood of compassion fatigue and burnout is also increased by perceptions of coworkers' stress, and a lack of control and autonomy in the workplace (Bemiller & Williams, 2011; McKim & Smith-Adcock, 2014). Inadequate training may leave advocates feeling unprepared to deal with trauma and crisis work, which further contributes to their risk of vicarious trauma (Merchant & Whiting, 2015).

With respect to organizational structure, hierarchical organizational structures and policies that are not aligned with trauma-informed practice contribute to vicarious trauma and burnout (Frey, Beesley, Abbott, & Kendrick, 2017). Workplace policies and procedures that are perceived as ineffective, unsupportive, or even abusive, also increase job dissatisfaction, and increase the likelihood that staff will move on (Merchant & Whiting, 2015). Witnessing or experiencing microaggressions within the workplace are also associated with higher risk of secondary traumatic stress (Wood et al., 2017), and workplaces that are emotionally demanding contribute to negative outcomes (Benuto et al., 2019). Finally, ineffective and anxiety-inducing communication can contribute to emotional exhaustion and burnout (Babin et al., 2012). Organizational risk factors

reported in the literature on system-based first responders include hierarchical and paramilitary organizational structures, and negative feedback systems (Adams, Shakespeare-Finch & Armstrong, 2015).

In addition to workplace demands and inadequate supports, community-based anti-violence workers may also have concerns about the risk of violence from perpetrators who have harmed their clients (Fusco, 2013; Ending Violence Association of BC, 2013).

### 4.2. Protective Factors

Individual protective factors that build resiliency against the impacts of vicarious trauma, secondary traumatic stress, and burnout include greater use of healthy coping strategies and longer tenure in the field (Kulkarni et al., 2013; Wood et al., 2017). Notably, while the academic literature on community-based anti-violence workers and system-based first responders emphasizes resiliency, some of the literature on system-based first responders uses alternative terms such as 'hardiness' (Klimley, Van Hasselt & Stripling, 2018); these terms reflect the gendered framing – and differential valuing – of each sector's work.

Workplace supports can also be protective, increasing job satisfaction and compassion satisfaction. For example, a supportive workplace or organizational culture is associated with increased retention (Merchant & Whiting, 2015). Increased control within the workplace, opportunities to have input and make decisions at work, having one's own workspace, lower workload, higher quality of supervision, and emotional support all increase job satisfaction and protect against the negative impacts of working with victims of trauma (Benuto et al., 2019; Frey et al., 2017; Kulkarni et al., 2013; McKim & Smith-Adcock, 2014; Wood et al., 2017; Wood et al., 2019). Higher quality relationships with colleagues, and socializing with co-workers, was also found to protect against work-related stress and to predict vicarious posttraumatic growth (Frey et al., 2017; Killian, 2008). Greater match with workplace values and working at a dual-focus agency also served as protective factors (Benuto et al., 2019; Kulkarni et al., 2013; Wood et al., 2017). Research suggests that compassion satisfaction may be able to counteract burnout, and the negative impacts of vicarious trauma, for community-based anti-violence workers (Cummings et al., 2018).

## 5. Impacts of Vicarious Trauma

The long-term psychological impacts of working in the community-based anti-violence sector, including vicarious trauma, secondary traumatic stress, posttraumatic stress injuries, and burnout, have been well documented in the literature; however, a comprehensive review of these impacts is beyond the scope of this paper. Notably, within

the grey literature reviewed, where the negative impacts of trauma (e.g., vicarious trauma, post-traumatic stress injuries) on community-based anti-violence workers are addressed, it is typically a subsection discussed within the context of supporting survivors of violence and/or trauma-informed practice more generally, and not a focus on the wellbeing of the workforce.

Community-based anti-violence work undertaken by women is frequently framed as benevolent caregiving, with workers often praised for their dedication and commitment, despite the negative personal impacts of selflessness and self-sacrificing (Hill, 2009). Long hours and working through breaks and lunches may be viewed as a sign dedication to the work; however, when community-based anti-violence workers ignore their personal needs and give up on maintaining healthy boundaries, they are at greater risk of burnout (Hill, 2009). The emotional demands of this work also lead many front-line workers to shut down emotionally (Bishop & Schmidt, 2011). Similar impacts have been noted in the literature on system-based first responders, many of whom may report feeling fatigued and emotionally disengaged (Adams et al., 2015; Basinska & Wiclak, 2012).

Work-related stress impacts the psychological and physical health of community-based anti-violence workers. For example, workers may experience changes in mood, becoming more anxious and impatient, or changes in the body, including tension, headaches, difficulties with concentrating and/or sleeping, and chronic exhaustion (Killian, 2008; Klinic Community Health Centre, 2013). Community-based anti-violence workers can experience symptoms similar to those experienced by their traumatized clients, including intrusive thoughts and hypervigilance, which may lead them to avoid their clients or use alcohol and other substances to cope (Klinic Community Health Centre, 2013; Lee, Gottfried & Bride, 2018). They may also experience feelings of hopelessness, helplessness, guilt, anger, and cynicism, which can impact their ability to empathize with clients (Klinic Community Health Centre, 2013). As such, negative health outcomes among community-based anti-violence workers ultimately impact the quality of care provided to victims of crime and trauma, and increase turnover in the sector as a whole (Hill, 2009); this is in contrast to the comparatively high retention rates for system-based first responders.

Vicarious trauma and secondary traumatic stress, along with low wages and poor supervision, contribute to lower job satisfaction and turnover intention (Wood et al., 2019). At the same time, there is evidence that compassion satisfaction contributes to higher job satisfaction (Wood et al., 2019), which can increase retention in the field.

Suicidal ideation, plans, and attempts are rarely discussed in the literature on community-based anti-violence worker wellness, and the impacts of working with victims of trauma; however, suicide is discussed within the literature on system-based first responders, as

an outcome associated with post-traumatic stress disorder and an impact of doing this work (Bigham, 2016; Carleton et al., 2018; Gulliver et al., 2016; Henderson, Van Hasselt, LeDuc & Couwels, 2016; Klimley et al., 2018; Koopmans, Wagner, Schmidt & Harder, 2017; Martin & Martin, 2017; Ramchand et al., 2019; Thoen et al., 2019).

## 6. Preventing Vicarious Trauma and Enhancing Worker Wellness

There are many strategies outlined in the literature for preventing vicarious trauma, secondary traumatic stress, and burnout, and increasing job satisfaction and compassion satisfaction among community-based anti-violence workers. While there are several prevention strategies that fall on the individual to protect themselves from the negative impacts of working with victims of crime and trauma, there is also a burgeoning literature that highlights the role of organizations and leadership in supporting staff through workplace culture, policies, and practices. This literature extends the concept of trauma-informed practice from its application to working directly with victims of trauma to the workers themselves, many of whom are also survivors.

### 6.1. Individual Prevention Strategies

Strategies that place the onus on individual workers to reduce their risk of experiencing vicarious trauma, secondary traumatic stress, and burnout include engaging in self-care activities, such as proper nutrition, regular exercise, socializing with friends and family, and spirituality (Killian, 2008). Community-based anti-violence workers are encouraged to engage in active self-care activities and coping strategies, such as engaging in extra-curricular activities and hobbies, and taking vacations, rather than less healthy coping mechanisms or passive self-care activities, such as avoidance and substance use (Hill, 2009). Notably, many effective self-care strategies require financial resources, which can be a barrier for underpaid community-based anti-violence workers. Engaging in more frequent self-care strategies has been found to increase compassion satisfaction (Wachter et al., 2019). The emphasis on ‘self-care’ strategies follows an understanding of anti-violence work within traditionally feminine terms, where the onus is on workers to ‘self-nurture’ or ‘mother’ themselves. Notably, in our review of the grey literature, it is rare for resources to acknowledge that anti-violence workers might use alcohol and/or drugs to cope with the impacts of trauma exposure; alcohol and drug use is generally considered to be a strategy utilized by men more than women, and is accordingly addressed much more frequently in grey literature about the impacts of trauma exposure on first responders.

Workers are also expected to set healthy boundaries, and maintain work-life balance (Choi, 2011). It is important to recognize, however, that setting boundaries may be much more difficult in small, rural, and isolated communities where advocates may have

relationships with victims, their families, and community members impacted by crime, violence, and trauma (Logan & Walker, 2018).

Informal support, such as emotional support and practical assistance are helpful, but many helping professionals are reluctant to share their experiences and struggles with others for fear of triggering or burdening them (Houston-Kolnik, Odahl-Ruan & Greeson, 2017). Social support networks may also not be equipped to provide the needed support, particularly if they have difficulty understanding or relating to community-based anti-violence workers' experiences (Houston-Kolnik et al., 2017). For this reason, community-based anti-violence workers often prefer to seek support from their colleagues who share similar experiences and understand what they are going through (Houston-Kolnik et al., 2017). Social support and connection with colleagues can serve as an antidote to the isolation of trauma work and is associated with compassion satisfaction (Killian, 2008; Merchant & Whiting, 2015). Yet, finding support from colleagues may be more difficult for minority and racialized anti-violence workers whose colleagues do not share similar experiences and/or culture, and for men who are less often socialized to seek emotional support from others (Houston-Kolnik et al., 2017). Community-based anti-violence workers often also seek counselling outside of work to process their feelings and prevent the negative impacts of doing this work (McKim & Smith-Adcock, 2014). However, staff use of personal counselling time to discuss and process work-related stress may be indicative of inadequate debriefing, clinical supervision, and social support within the workplace (Richardson, 2001).

Community-based anti-violence workers may also find meaning, and protection from the negative impacts of their work, by participating in research, policy work, and 'big picture' initiatives that seek to address systemic problems and prevent violence and trauma within their communities (Kulkarni et al., 2013).

### 6.2. Organizational Prevention Strategies

While community-based anti-violence workers often engage in individual self-care strategies, organizations also play an important role in the prevention of work-related stress, including vicarious trauma, post-traumatic stress injuries, and burnout (Benuto et al., 2019). Addressing structural issues is key to preventing these negative outcomes, yet "research on workplace wellness often neglects the role of organizational factors in preventing negative effects and promoting positive outcomes for service providers" (Kulkarni et al., 2013, p. 114).

Strategies to reduce occupational stress and work-related injuries, and improve job satisfaction, include supporting staff to engage in individual self-care strategies, reducing and balancing staff workloads, fostering social support and providing opportunities for

debriefing and supervision, increasing staff autonomy, and ensuring policies are clear and applied consistently, providing job training and education on preventing vicarious trauma, and offering competitive wages and extended health benefits.

At a minimum, organizations (especially leaders, managers, and supervisors) should work to foster a positive and supportive workplace culture, which signals to staff that the organization is committed to enhancing worker wellness and supports staff to engage in self-care activities (Wood et al., 2017). Organizations should contribute to the development of coping skills among staff, share ideas and resources for self-care, encourage staff to take breaks and time off, provide positive feedback, and share success stories (Bishop & Schmidt, 2011; Wood et al., 2019). Leadership should also encourage and build time into the work day for coping behaviours and wellness strategies, such as mindfulness, meditation, exercise, and socializing (Kulkarni et al., 2013; Wachter et al., 2019; Wood et al., 2017). While resources are extremely limited within community-based anti-violence organizations, other suggestions for enhancing worker wellness include providing healthy snacks and refreshments for staff, where possible, or negotiating non-profit or group rates at recreational facilities.

Supervisors and managers should work to limit the number of hours of direct victim or trauma work that each community-based anti-violence worker takes on, balance workloads among staff, and reduce workloads so that they feel manageable (Benuto et al., 2019; Wachter et al., 2019; Wood et al., 2017; Wood et al., 2019).

Social support and supervision are key strategies for enhancing community-based anti-violence worker wellness (Van Veen & Lafrenière, 2012; Wood et al., 2019). Staff should be encouraged to build supportive and collegial relationships with one another (Klinic Community Health Centre, 2013; Richardson, 2001; Wood et al., 2017), and have been found to benefit from a culture of teamwork and ongoing support from coworkers, supervisors, and managers (Choi, 2011; Klinic Community Health Centre, 2013). Supporting communication, connection, and community building that provide staff with opportunities to discuss positive and negative experiences can also contribute to a healthier workforce (Bemiller & Williams, 2011; Frey et al., 2017; Wood et al., 2017).

Regular access to high quality supervision is critical to prevent the negative impacts of trauma work (Dworkin et al., 2016; Richardson, 2001; Wood et al., 2019). This includes regular debriefing meetings and clinical supervision to process challenging client material (Babin et al., 2012; Bishop & Schmidt, 2011; McKim & Smith-Adcock, 2014). Some organizations also offer support groups to volunteers, but these must be offered at times when volunteers are able to attend in order to meet the needs of those they are designed to support (Houston-Kolnik et al., 2017).

Supervisors should be especially mindful of the needs of younger staff and staff with personal histories of trauma, recognizing their increased risk of vicarious trauma (Dworkin et al., 2016). Formalized mentorship programs may be helpful in this regard, so that more experienced staff can serve as role models, share insights, and provide social support to younger or newer community-based anti-violence workers (Babin et al., 2012; Kulkarni et al., 2013). Supervisors should also prioritize supports for those who provide direct support to victims of crime and trauma, given that trauma work increases the risk of vicarious trauma, compassion fatigue, and burnout (Wood et al., 2017). Organizations must create effective supervision structures and opportunities for debriefing, and enhance organizational coping strategies, such as the development of team care plans (Wachter et al., 2019; Wood et al., 2017).

Another organizational strategy to enhance worker wellness is to increase community-based anti-violence workers' sense of autonomy and control over their work (Wood et al., 2019). This may include opportunities to provide input regarding the type of work or cases assigned to them, core hours and/or flex-time to allow for more control over work hours, and time away from work (Bemiller & Williams, 2011). Providing staff with access to information about external factors that impact the work of the organization, and opportunities to participate in the development of the organization's strategic priorities and decision-making processes, may also enhance wellness (Choi, 2011; Klinic Community Health Centre, 2013; McKim & Smith-Adcock, 2014).

Clear workplace guidelines and policies for staff, volunteers, and Board members, consistency and fairness in the application of workplace policies, clarity about structures and roles, clear communication and transparency, and well-articulated organizational values are all important for worker wellness (Klinic Community Health Centre, 2013; Richardson, 2001; Wood et al., 2017). Policies and training on anti-oppressive practice and strategies to prevent and address microaggressions and bullying in the workplace are also important for ensuring a safe and healthy workplace (Wood et al., 2017; Wood et al., 2019). Job training, training on communication and stress management, and education on vicarious trauma are critical for preventing vicarious trauma, secondary traumatic stress, and burnout in the community-based anti-violence sector (Babin et al., 2012; Bishop & Schmidt, 2011; Wachter et al., 2019; Wood et al., 2017). In one study of transition house workers in northern British Columbia, only one third had received training on vicarious trauma (Bishop & Schmidt, 2011).

While the community-based anti-violence sector is woefully underfunded, competitive salaries, extended health benefits, self-care or personal days, and leave options for workers can all help to mitigate the negative impacts of trauma work, such as vicarious trauma (Richardson, 2001; Wood et al., 2017; Wood et al, 2019).

To summarize, workplace supports, combined with individual self-care strategies, enhance worker wellness and protect against vicarious trauma and burnout (Richardson, 2001, p. 56). Without organizational support, staff often feel resentful for having to manage these impacts on their own (Merchant & Whiting, 2015).

### 6.3. Sector-Wide Prevention Strategies

Community-based anti-violence workers would benefit significantly from more workplace guidance and support, as well as training to build capacity, including skills to provide more effective support and safety planning (Logan & Walker, 2018).

Developing effective screening tools for vicarious trauma, secondary traumatic stress, and burnout, as well as intervention strategies that anti-violence organizations can implement to increase compassion satisfaction and reduce burnout, will ultimately reduce the number of sick days (including mental health days) taken by anti-violence workers, reduce the high turnover rate in the field, and increase the quality of services and care provided to victims of crime and trauma (Cummings et al., 2018).

Self-awareness and an understanding of vicarious trauma are considered critical components of community-based anti-violence work (BC Provincial Mental Health and Substance Use Planning Council, 2013), placing the onus on individual workers to address the negative impacts of their work. Anti-violence workers are asked to address the trauma they are exposed to through *awareness* of their own needs, limits, emotions, and resources; *balance* of all aspects of the self, including work-life balance; and *connection* with themselves, others, and the world to help offset isolation; these are collectively referred to as the ABCs of addressing 'trauma exposure response' (Klinic Community Health Centre, 2013). **Anti-violence organizations are additionally tasked with promoting trauma-informed practice for staff, in addition to clients, without adequate funding or external supports.**

A trauma-informed approach to the work recognizes that being exposed to trauma has negative impacts, similar to the impacts of experiencing trauma. When it comes to dealing with those trauma impacts, however, it is often individual anti-violence workers and community-based organizations that are tasked with preventing these harmful impacts. This stands in stark contrast to the systemic approaches we see reflected in Canada's federal initiatives to address PTSD and occupational stress injuries in first responders and public safety personnel (described below).

## 7. Comparison of Community-Based and Systems-Based Workers

The discrepancy between prevention strategies and workplace supports available to enhance worker wellness among community-based anti-violence workers and system-based first responders is significant. The literature on system-based first responders emphasizes the need to protect first responders so that they can continue to protect the public: "...public safety personnel with [post-traumatic stress] injuries need to have immediate access to care and treatment so that they can be strong and healthy, and continue to keep Canadians safe." (Public Safety Canada, 2019, p. 7). It is not uncommon for system-based first responders to have access to training, peer support programs, Critical Incident Stress Management (CISM), and/or Employee Assistance Programs (EAPs) (Donnelly et al., 2015; Klimley et al., 2018). The research also points to interventions such as Cognitive Behavioural Therapy, Cognitive Processing Therapy, Brief Eclectic Psychotherapy, and Eye Movement Desensitization and Reprocessing (Lanza, Roysircar & Rodgers, 2018).

The grey literature reviewed reveals a significant number of reports, articles, and guides for preventing and addressing the impacts of trauma work among first responders, such as police, firefighters, and paramedics. These professions are traditionally dominated by men, and much of the literature references the conceptions of 'masculine' strength and stoicism that may act as barriers for workers experiencing trauma impacts. The stigma of trauma impacts on psychological wellbeing is seen as "exponentially more pervasive because of the added 'suck it up' attitude" (Crean, 2015, p. 5) that exists in first responder institutions. These sectors have workplace cultures that view help-seeking as weakness, compounded by a "belief that the job comes first and their lives, feelings, and families come second" (as cited in Oliphant, 2016, p. 11). Accordingly, efforts to address the impacts of trauma work on first responders actively acknowledge the stigma as a barrier, and work to reframe trauma impacts so as to not suggest weakness (see Oliphant, 2016; Crean, 2015). The academic literature points to the value of peer support programs for system-based first responders as a way to normalize and facilitate reaching out for support (Klimley et al., 2018; Marks et al., 2017).

There are a number of trainings available to system-based first responders across Canada, to help them address trauma impacts and support their mental wellness, including Resilient Minds (provided by the Canadian Mental Health Association); R2MR — Road to Mental Readiness (based on courses developed by the Canadian Armed Forces); and Mental Health First Aid Basic (provided by Mental Health First Aid Canada). These trainings work to support first responders at all levels by enhancing their knowledge of a number of relevant topics, including: common mental health conditions in first responders (Post-traumatic Stress Disorder, depression, anxiety, substance use); signs and symptoms of mental health conditions (including suicide risk) in themselves and

others; how to respond to a co-worker exhibiting signs or symptoms of mental ill health; stress-related risk factors; legal obligations related to mental health; behavioural and attitudinal changes related to mental health; mental health resources (e.g., Employee Assistance Programs, employer benefits); and how to provide workplace accommodations (BC First Responders Mental Health, 2017). Conversely, for community-based anti-violence workers, Cummings and colleagues (2018) note that **"no interventions exist to combat these psychological responses that are incurred in the victim advocate profession"** (p. 6).

7.1. Presumptive Coverage of Occupational Mental Health Claims Across Canada

Presumptive coverage for occupational stress injuries explicitly links specific impacts (e.g., PTSD) with certain occupations (e.g., first responders), removing crucial barriers in accessing support following a diagnosis. When looking at occupational mental health claims, there is considerable variation across the provinces and territories. The table below outlines, for each province and territory, the inclusion of presumptive coverage for occupational mental health claims for the following occupations: police, firefighters, paramedics, and community-based anti-violence workers.

| | AB | BC | SK | MB | ON | QC | NB | NS | PE | NL | YK | NT | NU |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Police | ✓ | ✓ | ✓ | ✓ | ✓ | × | ✓ | ✓ | ✓ | ✓ | ✓ | × | × |
| Firefighters | ✓ | ✓ | ✓ | ✓ | ✓ | × | ✓ | ✓ | ✓ | ✓ | ✓ | × | × |
| Paramedics | ✓ | ✓ | ✓ | ✓ | ✓ | × | ✓ | ✓ | ✓ | ✓ | ✓ | × | × |
| Anti-Violence | × | × | ✓ | ✓ | × | × | × | × | ✓ | ✓ | × | × | × |

As of September 2019, all jurisdictions across Canada – with the exception of Quebec, the Northwest Territories and Nunavut – had presumptive legislation in place for occupational mental health claims (Minister of Justice Canada, 2018, p. 45). While most provinces and territories have presumptive coverage that is limited to Post-Traumatic Stress Disorder (PTSD), a few provinces have broader legislation that accounts for other psychological occupational stress injuries (Minister of Justice Canada, 2018, p. 45). While some provinces and territories legislate presumptive coverage for workers all occupations experiencing psychological occupational stress injuries, where specific occupations *are* named, community-based anti-violence workers are consistently absent.

## 7.2. Federal Action to Address Posttraumatic and Occupational Stress Injuries in Public Safety Personnel

Across Canada, provincial and territorial legislation has been inconsistent in its response to trauma impacts on first responders and public safety personnel (see Bailey, 2017; Bigham, 2016). In recent years, Canada has made significant headway at a federal level in addressing Occupational Stress Injuries (OSI), including Post-Traumatic Stress Injuries (PTSI). The Standing Committee on Public Safety and National Security developed a report articulating recommendations to Public Safety Canada to inform a national strategy for addressing operational stress injuries experienced by public safety officers. These recommendations include the need for: additional data collection and comprehensive research; an Occupational Stress Injuries expert working group and advisory council; and the exploration of federal legislation that would include a presumption of Occupational Stress Injuries for public safety officers under federal jurisdiction. Bill C-211: Federal Framework on Post-Traumatic Stress Disorder Act (Minister of Justice Canada, 2018) also required the Minister of Health Canada to convene a conference to support the development of a comprehensive federal framework addressing Post-Traumatic Stress Disorder.

Public Safety Canada (2019) has now delineated an Action Plan for addressing post-traumatic stress injuries among public safety personnel, focused on: investing in research and data collection; advancing efforts in prevention, early intervention, and stigma reduction; and support for care and treatment. This national Action Plan builds on other recent Government of Canada initiatives to support public safety personnel with PTSI, including: $10 million for an online pilot of Cognitive Behavioural Therapy; $10 million toward a longitudinal mental health study of Royal Canadian Mounted Police (RCMP) new recruits; $11 million in grants for research into PTSI in public safety personnel; $187,000 to support training public safety personnel on the Canadian Armed Forces' Road to Mental Readiness (R2MR) program; establishing a Memorial Grant for family members of first responders "who have died as a result of their duties" (pp. 15-16), including by suicide; and the inclusion of this Action Plan as a key component of a broader Federal Framework on PTSD (Public Safety Canada, 2019).

There has been extensive discussion regarding which occupations should fall within this federal strategy. In its recommendations, the Standing Committee on Public Safety and National Security (2016) emphasizes the need for a clear and consistent definition of 'public safety officer', and recommends that this category be broadly defined to include firefighters, police, paramedics, corrections officers, and employees of the Correctional Service of Canada, border services officers, and Indigenous emergency managers, as well as other emergency personnel who work alongside and support public safety officers. Bill C-211, the Federal Framework on Post-Traumatic Stress Disorder Act (Minister of

Justice Canada, 2018), focused on PTSD experienced by first responders, firefighters, military personnel, corrections officers, and members of the RMCP. Public Safety Canada (2018) similarly defined 'public safety personnel' as "broadly [encompassing] front-line personnel who ensure the safety and security of Canadians across all jurisdictions" (p. 3), providing the examples of police, firefighters, paramedics, correctional employees, border services personnel, operational and intelligence personnel, search and rescue personnel, Indigenous emergency managers, and dispatch personnel.

While the breadth of occupations included does vary, the trauma impacts experienced by community-based anti-violence workers have been consistently absent from federal discussions of OSI and PTSI. The Standing Committee on Public Safety and National Security (2016) does acknowledge that those who *work alongside* or *support* public safety personnel may also experience OSI; however, as it applies to work with people who have experienced crime and violence, including gender-based violence, the focus remains on systems-based responders to the exclusion of community-based anti-violence workers. This exclusion mirrors the academic literature on public safety personnel that consistently leaves out community-based anti-violence workers (Carleton et al., 2018, 2019).

The Canadian Association of Social Workers (Bailey, 2017) has called for the inclusion of social workers in federal OSI and PTSI initiatives, noting that "practicing social workers, especially those on the front line, are also at higher risk of [Occupational Stress Injuries] and should be included in the group of occupations covered under the proposed national policy" (p. 5). Social workers, counsellors, and other helping professionals who support victims of crime and trauma may be included if they work within systems (e.g., health care system, child protection). Many community-based anti-violence workers are trained as social workers and counsellors, but do not have the benefit of these supports because they work in community-based organizations or the anti-violence sector, a sector that is undervalued and dominated by women who are often conceived of as natural caretakers (Rossiter et al., 2014).

## 8. Conclusions

Vicarious trauma, secondary traumatic stress, posttraumatic stress injuries, and burnout impact all responders, including community-based anti-violence workers, organizations, and the sector as a whole, which in turn impact the quality of services delivered to victims of violent crime. Working in this field is important and meaningful work, and thus workers continue to do this work, despite challenging work environments, a phenomenon described in the literature as "good soldiering" (Bemiller & Williams, 2011). It is clear from the literature review that there is significantly more research, legislation, policy, training, and workplace support for system-based first responders, such as police, firefighters, and paramedics, compared to community-based anti-violence workers, despite similar risks

of experiencing vicarious trauma, secondary traumatic stress, posttraumatic stress injuries, compassion fatigue, and burnout as a result of their work to support victims of crime and trauma. Governments should be applauded for recognizing the work-related and posttraumatic stress injuries of system-based first responders, and equivalent supports should be available for the community-based anti-violence sector, given their similar benefit to public safety and the risks associated with the work. Several recommendations for the Office of the Federal Ombudsman for Victims of Crime are made below to address these discrepancies and enhance the wellness of community-based anti-violence workers.

## 9. Recommendations

I. Communicate to the relevant federal government departments and leadership (including the Minister of Justice and Attorney General, Minister of Public Safety and Emergency Preparedness, Minister of Labour, and Minister for Women and Gender Equality) the significant impacts of trauma exposure for the anti-violence workforce.

II. Fund further research on work related occupational injuries in the anti-violence sector to increase knowledge about the short-term and long-term impacts of doing this work, including health implications, and inform evidence-based policy that addresses these impacts.

III. Highlight discrepancies between prevention strategies and workplace supports for system-based first responders and community-based anti-violence workers, and advocate for the inclusion of anti-violence workers in federal action and provincial and territorial initiatives to address posttraumatic and occupational stress injuries among public safety personnel.

IV. Advocate to the Minister for Women and Gender Equality the critical need to acknowledge the lack of prevention strategies related to occupational stress injuries for community-based anti-violence workers as an urgent gender equality issue.

V. Recommend that the Minister of Labour and the Minister of Health support research and initiatives to address the impacts of trauma exposure on community-based anti-violence workers as a workplace health issue.

VI. Recommend the development of a Federal-Provincial-Territorial committee to examine the provision of better supports and funding for anti-violence organizations to prevent vicarious trauma, secondary traumatic stress, and

posttraumatic stress injuries among anti-violence workers, including addressing provincial/territorial differences in wages, benefits, pensions, and FTEs.

VII. Encourage the federal government to support the development and delivery of training for anti-violence workers, including core training for new workers so they are better prepared to undertake trauma work, and have a better understanding of vicarious trauma, secondary traumatic stress, and posttraumatic stress injuries, and strategies to address these negative outcomes of working with victims of crime and trauma.

VIII. Encourage the development of social policy that recognizes all forms of gender-based violence as critical issues that require training and best practices across all sectors, so that anti-violence workers are not further harmed by the inadequate responses of other sectors (e.g., justice, health, housing) that respond to victims of crime and trauma, including gender-based violence.

IX. Convene relevant Ministers (including the Minister of Justice and Attorney General, Minister of Labour, Minister of Health, Minister of Families, Children and Social Development, Minister of Public Safety and Emergency Preparedness, Minister for Women and Gender Equality) to communicate with provincial counterparts to consider labour code amendments to address the wellness of anti-violence workers and the inclusion of PTSD injury supports parallel to those provided to system-based first responders, including the classification of anti-violence workers' post-traumatic stress injuries as a workplace injury eligible for presumptive coverage.

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## Appendix A. Provincial and Territorial Presumptive Coverage of Occupational Mental Health Claims

The tables below outline, for each province and territory, the inclusion of presumptive coverage for occupational mental health claims for the following occupations: police, firefighters, paramedics, and community-based anti-violence workers.

### Alberta (AB)

| | |
|---|---|
| Police | ✓ |
| Firefighters | ✓ |
| Paramedics | ✓ |
| Anti-Violence | × |

Alberta's *Workers' Compensation Act* legislates presumptive coverage for PTSD for: firefighters (full- and part-time); emergency medical technicians (EMT); police officers; peace officers, correctional officers; and emergency dispatchers (Workers' Compensation Board – Alberta, 2018). Community-based anti-violence workers are not an occupation identified for presumptive coverage.

### British Columbia (BC)

| | |
|---|---|
| Police | ✓ |
| Firefighters | ✓ |
| Paramedics | ✓ |
| Anti-Violence | × |

British Columbia's *Workers Compensation Act* was amended to include a 'mental disorder' presumption for: correctional officers, emergency medical assistants (i.e., paramedics and first responders), firefighters, police officers, sheriffs, and "any other occupation prescribed by the by the regulation of the Lieutenant Governor in Council" (WorkSafeBC, 2018). Community-based anti-violence workers are not an occupation identified for presumptive coverage.

**Saskatchewan (SK)**

| | |
|---|---|
| Police | ✓ |
| Firefighters | ✓ |
| Paramedics | ✓ |
| Anti-Violence | ✓ |

Saskatchewan's *Workers' Compensation Act* extends "a presumption for all forms of psychological injury incurred through work, not just post-traumatic stress disorder (PTSD) and to apply this to all workers" (Saskatchewan Workers' Compensation Board, n.d.), which would include community-based anti-violence workers.

**Manitoba (MB)**

| | |
|---|---|
| Police | ✓ |
| Firefighters | ✓ |
| Paramedics | ✓ |
| Anti-Violence | ✓ |

In Manitoba, presumptive coverage of PTSD is inclusive of all workers covered by workers compensation, recognizing that "PTSD-triggering events can happen in any workplace" (Workers Compensation Board of Manitoba, 2016). This presumptive coverage of PTSD would include community-based anti-violence workers.

**Ontario (ON)**

| | |
|---|---|
| Police | ✓ |
| Firefighters | ✓ |
| Paramedics | ✓ |
| Anti-Violence | ✗ |

Ontario's *Workplace Safety and Insurance Ac*t (WSIB Ontario, 2018) includes presumptive PTSD coverage for "first responders and other designated workers", a category which includes firefighters (full-time, part-time, and volunteers) and fire investigators; police officers; members of emergency response teams; paramedics; emergency medical attendants; ambulance service managers, workers in correctional institutions, places or secure custody, or places of secure temporary detention; dispatch workers; nurses who provide direct patient care; provincial bailiffs; probation officers and their direct supervisors; special constables; and police force members who work in a

forensic identification unit or a Violence Crime Linkage Analysis System unit. Community-based anti-violence workers are not an occupation identified for presumptive coverage.

**Quebec (QC)**

| | |
|---|---|
| Police | ✕ |
| Firefighters | ✕ |
| Paramedics | ✕ |
| Anti-Violence | ✕ |

Quebec's *Workers' Compensation Act* (CSST, 2005) does not appear include presumptive coverage for 'psychological impairment', such as PTSD, for any occupations.

**New Brunswick (NB)**

| | |
|---|---|
| Police | ✓ |
| Firefighters | ✓ |
| Paramedics | ✓ |
| Anti-Violence | ✕ |

In New Brunswick's *Worker Compensation Act*, PTSD presumption applies to 'emergency response workers,' which is defined as including firefighters, paramedics, and police officers (WorkSafeNB, 2019). Community-based anti-violence workers are not an occupation identified for presumptive PTSD coverage.

**Nova Scotia (NS)**

| | |
|---|---|
| Police | ✓ |
| Firefighters | ✓ |
| Paramedics | ✓ |
| Anti-Violence | ✕ |

In Nova Scotia, the *Workers' Compensation Act* PTSD presumption applies to 'frontline and emergency response occupations,' which have been defined as including: police; firefighters (pain and volunteer); paramedics; nurses; correctional officers (including youth workers); continuing care assistants, emergency response dispatchers; police officers; and sheriffs (Workers Compensation Board of Nova Scotia, 2018). Community-based anti-violence workers are not an occupation identified for presumptive PTSD coverage.

**Prince Edward Island (PEI)**

| | |
|---|---|
| Police | ✓ |
| Firefighters | ✓ |
| Paramedics | ✓ |
| Anti-Violence | ✓ |

In Prince Edward Island, the *Workers Compensation Act* (2019) includes presumptive coverage for trauma- and stressor-related disorders applies to all workers, including community-based anti-violence workers.

**Newfoundland and Labrador (NL)**

| | |
|---|---|
| Police | ✓ |
| Firefighters | ✓ |
| Paramedics | ✓ |
| Anti-Violence | ✓ |

In Newfoundland and Labrador, presumptive coverage for PTSD applies to all workers, including community-based anti-violence workers (WorkplaceNL, 2019).

**Yukon Territories (YT)**

| | |
|---|---|
| Police | ✓ |
| Firefighters | ✓ |
| Paramedics | ✓ |
| Anti-Violence | ✗ |

In the Yukon Territories, the *Workers' Compensation Act* (2008, pp. 22-23) includes a PTSD presumption for emergency response workers, a category that includes firefighters (full-time, part-time, or volunteer), paramedics, and police officers (Government of Yukon, Community-based anti-violence workers are not an occupation identified for presumptive coverage.

**Northwest Territories (NT)**

| | |
|---|---|
| Police | ✕ |
| Firefighters | ✕ |
| Paramedics | ✕ |
| Anti-Violence | ✕ |

The Northwest Territories' *Workers' Compensation Act* (2020, p. 27) addresses 'personal injury, disease, or death' and does not appear to include presumptive coverage for occupational stress injuries, such as PTSD, for any occupations.

**Nunavut (NU)**

| | |
|---|---|
| Police | ✕ |
| Firefighters | ✕ |
| Paramedics | ✕ |
| Anti-Violence | ✕ |

Nunavut's *Workers' Compensation Act* (2015, p. 9) addresses 'personal injury, disease, or death' and does not appear to include presumptive coverage for occupational stress injuries, such as PTSD, for any occupations.