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# Behind the Frontlines: Exploring the Mental Health and Help-seeking Behaviours of Public Safety Personnel Who Work to Support Traditional Frontline Operations

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**Abstract:**

In public safety, individuals working behind what are often traditionally thought of as the frontlines, such as dispatchers, 911 operators, administrators, health professionals, and civilian police officers, as well as non-deployed police and correctional officers, firefighters, and paramedics, provide invaluable and needed support for frontline employees. Yet, too often the occupational stress and

trauma they experience is less recognized or acknowledged. Drawing on qualitative data from an online Canadian survey, where 828 persons provided feedback when asked if they had any final comments, we explore how public safety personnel who are not deployed to incidents or working on the traditional frontline interpret occupational stressors and the justice underpinning their access to mental health supports. Emergent themes reveal those working to support traditional frontline operations also experience trauma and struggle with help-seeking behaviours—specifically they: i) feel like outsiders; ii) are mired with self-doubt while trying to recognize and validate their own struggles with mental health; and iii) express despair that there is no improvement for their situation. Findings are discussed within the context of the justice underpinning such struggles of validating their difficulties.

**Keywords:** Public Safety; Trauma; Stigma; Mental Health; Qualitative Data

## Introduction

For individuals working in the broad area of public safety (e.g., first responders, public safety officers or personnel), inherent in their job tasks is the regular and expected exposure to potentially traumatic events (Berger et al., 2012; Carleton, Afifi, Taillieu, Turner, Krakauer et al., 2018; Carleton, Afifi, Turner, Tallieu, Duranceau et. al., 2017; Komarovskaya et al., 2011). In some occupational roles, such as police officers on patrol or correctional officers working on units directly with prisoners, employees have primary trauma exposures, directly experiencing the event during their occupational duties. Other individuals, working behind the traditional (in-person) frontlines, such as dispatch, 911 operators, transcription, non-deployed police officers, fire fighters or paramedics, or correctional officers posted off units, have secondary and vicarious traumatic exposures which can be acquired by witnessing, reading about, or listening to graphic and/or traumatic accounts or records of the event (Baird & Kracen, 2006).

The challenge, however, arises if those working in public safety roles that are not on what is traditionally understood as "the frontline" (e.g., those who are not first on scene or are not deployed to the scene of an incident) do not receive recognition of the potentiality for their occupational duties to impact their wellbeing, and thus the same access to support. In essence, they are less recognized because they are not at the scene or because their occupational responsibilities do not or no longer include working in person on the frontline—they hold occupational roles that are essential to public safety but are largely peripheral to frontline roles. It is those persons in such roles that we consider here as working "behind the (traditional) frontline"; they often experience the trauma of the "frontline" as they provide support operations laced with additional layers of stress, which shape unique mental health challenges and help-seeking behaviours compared to those working on the traditional frontline. Accordingly, we explore how those in such public safety roles understand their occupational roles and how they interpret and experience occupational stressors. There is a need to provide care and support for those who keep society safe, and failing to do so creates an unhealthy workforce that impedes the presentation and enactment of justice—access to justice is then compromised.

We interpret access to justice as an evolving and multidimensional concept, where a lack of justice is inherent in many ways, such as perceived or real inequalities in access to and the availability of interventions, or even in regard to public safety personnel (PSP) who experience compromised wellbeing due to the realities of their occupation. In such cases, the nature of their job may result in PSP being made to feel their needs and experiences are invalid or illegitimate. Injustice is also inherent in the perceived lack of respect and appreciation for the work these PSP perform and their role in keeping society safe. In addition, access to justice is stalled for those with whom PSP interact. Specifically, failing to acknowledge and respond to the wraparound effects of dissatisfied and hurt PSP, who may become increasingly negative or impatient, among other traits,

impedes the experiences of those with whom PSP interact, negatively affecting the experiences of the citizens with whom they come into contact when doing their jobs. Here, the traditional understandings of access to justice (i.e., to lawyers, a fair trial, and so on) also can be compromised for citizens—even momentarily—by the compromised capacity of those public servants who are under tremendous stress and who feel invalidated or undervalued in their positions. As such, *justice* is interpreted as fair and equitable recognition, and thus validation and *access* to the support all persons responsible for public safety should be awarded. Said another way, the injustice in access, we argue, emerges also when the wraparound effects of compromised PSP wellbeing—in their personal and work lives, and their impact on the experiences of citizens who come into contact with said PSP within systems of public safety—are ignored and deemed invalid.

We divide this paper into four parts. First, we unpack the evolution of the concept of PSP, the occupational nuances of working behind the traditional "frontline," and the roles of stigma in help seeking. Next, we present our current study and method. In the third section, we reveal findings tied to how PSP in support roles report feeling like outsiders; being mired with self-doubt about the validity of their mental health needs, and despair about if their situation can improve. To end the paper, we reflect on the justness of needing to legitimize an occupation that has exposure to trauma as part of its requirement, as well as the concomitant negative impacts on mental health, before noting the limitations of our study and need for future research in the area.

## *Public Safety Personnel: An Evolving Concept*

In January of 2016, Public Safety Canada hosted a Ministerial Roundtable on Post-Traumatic Stress Disorder (PTSD) as part of its mandate to develop a "coordinated national action plan on PTSD" (Public Safety Canada, 2016, p. 3). The term "public safety officer" was used to broadly capture the group of "front-line personnel who ensure the safety and security of Canadians, including tri-services (fire, police and paramedics), search and rescue personnel, correction

services officers, border services officers, operational intelligence personnel and Indigenous emergency managers" (Public Safety Canada, 2016, p. 3). The Roundtable explored the occupational experiences and risk associated with those on the "frontlines" who might, by nature of their work, be at risk for an Operational Stress Injury (OSI) such as PTSD. Originating from the Canadian Armed Forces and Royal Canadian Mounted Police, an OSI has been defined as "persistent psychological difficulty resulting from operational duties" (Veterans Affairs Canada, n.d.). Despite the broadening of the mandate from PTSD to OSI, the populations prioritized through invitation to the Roundtable were the representatives of the tri-service sectors (i.e., firefighting, paramedicine, policing).

A period of consultation with the broader public safety community ensued to build upon the discussions within the Roundtable, eliciting a range of feedback from other stakeholders. In the October 2016 Report of the Standing Committee on Public Safety and National Security, a key recommendation was that "other emergency personnel who work alongside and support public safety officers" be integrated within the national strategy to address OSIs, as those roles also have endemic risk (Oliphant, 2016, p. 7). Furthermore, the committee called for, by name, the "Canadian Institute for Public Safety Officer Research and Treatment" to be formalized. The scientists within the developing institute started to examine variations in how provincial and federal legislation define public safety officers and first responders, and requested more feedback from the public safety communities. The initial Canadian Institute for Public Safety Research and Treatment (CIPSRT) team was formed, using the term "public safety personnel" (PSP) instead of "public safety officer" to ensure inclusiveness. PSP includes all of the various groups responsible for, and dedicated to, the security and safety of the Canadian population (Carleton, Afifi, Turner, Taillieu, Duranceau et al., 2017; Ricciardelli, Carleton, Cramm, & Groll, in press).

Defining and understanding who is included within the category of PSP remains a challenging and ongoing process. If used too broadly,

PSP might be perceived by some as over-reaching by including any persons working in any context related to public safety, which some might argue is all persons; however, some might perceive PSP as being too narrow, excluding persons whose occupations warrant inclusion. An overly narrow perception of PSP risks excluding occupations that already feel under-recognized even as they contribute to supporting the wellbeing of persons exposed to potentially traumatic events. An example of the impact of this disparity in terminology, mirrored in the research literature, is how those working in occupations that are never on the traditional in-person frontline, such as communication specialists (e.g., dispatchers, 911 operators, etc.) and non-sworn civilian police, report feeling that their experiences and risks are overlooked and neglected relative to those who operate in the field (Coxon et al., 2016; Golding et al., 2017; Shakespeare-Finch, Rees, & Armstrong, 2015; Steinkopf, Reddin, Black, Van Hasselt, & Couwels, 2018).

Organizational supports within agencies may be differentially accessible across employees in different occupational roles. For example, civilian police services employees report receiving less organizational support from their supervisors and administration relative to sworn police officers (McCarty & Skogan, 2012), feeling unaccepted (or as outsiders) by sworn officers (Alderden & Skogan, 2014), and experiencing high levels of organizational stress, such as having limited control over their work or work outcomes (Adams, Shakespeare-Finch, & Armstrong, 2015; Golding et al., 2017; Steinkopf et al., 2018). The disparities within organizational supports for traditional "frontline" employees versus "behind the frontline" employees, all with fundamental roles in public safety, may first emerge during training if support PSP lack access to, or have a perceived need for, education around traumatic stress, stress management, and resilience (Coxon et al., 2016; Forslund, Kihlgren, & Kihlgren, 2004). In a recent qualitative study of dispatchers in the United Kingdom, Coxon and colleagues (2016) demonstrated that communication specialists feel poorly understood, undervalued, and unsupported by the public, their friends, and families, and feel

unacknowledged or unaccepted as integral members of the team among the frontline PSP (Coxon et al., 2016).

Despite differences between job requirements of employees at or behind the frontline, PSP behind the frontline often have stressful jobs with regular, ongoing exposure to potentially traumatic events. For example, physiological indicators of stress indicate that dispatchers' cortisol levels increase significantly during work, relative to control groups, even after a period of rest from work (Weibel, Gabrion, Aussedat, & Kreutz, 2003). Their jobs are undeniably intensive with lives hanging in the balance. Communication specialists simultaneously engage with high levels of responsibility to gather information from distressed callers, manage available resources, potentially coach callers through time-critical provision of emergency first aid, and switch between emergency protocols, all while creating good rapport with the caller and ensuring that help is routed to the correct location (Coxon et al., 2016; Kashani, Sanko, & Eckstein, 2018; Shakespeare-Finch, Rees, & Armstrong, 2015; Steinkopf et al., 2018). In addition, communication specialists must navigate the challenges of a high volume of calls, shiftwork, communication difficulties, and ambiguous information, all with little access to learning the outcome for a given caller (Forslund et al., 2004; Kashani et al., 2018). Calls that involve risk to children or professional colleagues can be especially taxing and wrought with emotion (Gallagher & McGilloway, 2008; Pierce & Lilly, 2012). Given the nature of their operational responsibilities, communication specialists are at risk of "repeated or extreme indirect exposure to aversive details of the events," which aligns with a PTSD diagnostic criterion in the Diagnostic and Statistical Manual of Mental Disorders, or DSM-5 (American Psychiatric Association, 2013). In the United States, Steinkopf and colleagues (2018) administered an assessment battery to 100 emergency dispatchers in Florida, revealing that communication specialists experienced psychological and occupational stress, as well as sub-threshold

PTSD, at rates similar or higher to those of police officers (Steinkopf et al., 2018).

Communication specialists have a specific and demanding role to play within the first responder team, and other PSP work in ways that may be even more removed from the frontlines; nevertheless, communication specialists also experience high stress and the potentiality for ongoing traumatic exposures. For example, computer forensic employees or police officers working in Internet Child Exploitation (ICE) units may not be deployed to incidents but still may see and hear disturbing and graphic media, resulting in substantial levels of traumatic stress as well as PTSD (Burns, Morley, Bradshaw, & Domene, 2008; Krause, 2009; Perez, Jones, Englert, & Sachau, 2010). Others, like probation officers, may experience a range of potentially traumatic events including assaults and/or threats to themselves, the completion of suicide by someone under their supervision, and the pains of watching those on their caseload experience rejection, neglect, or isolation—all job-related stressors that can result in increased experiences of traumatic stress (Lewis, Lewis, & Garby, 2013; Rhineberger-Dunn, Mack, & Baker, 2016; Ricciardelli & Peters, 2017). When experiences of stress and needs go unrecognized or are placed as secondary to other PSP, there is a risk of additional harm caused by perceptions of injustice. Moreover, the diverse roles within public safety organizations and the communities within which they are embedded can impact how employees are identified or self-identify professionally, which can have wraparound effects for their personal identity. Perceived or real inequalities in treatment and regard for PSP create barriers to justice that can compromise wellbeing and identity, shaping access or experiences of the criminal justice processes of public citizens.

### *Stigma and Help Seeking*

Bearing a stigma is "the situation of the individual who is disqualified from full social acceptance," which can be for any of three broad attributes: physical markers on the body, characteristics of person (e.g., criminal status), or group affiliation (Goffman, 1963, p. 9). Stigma underpins labelling, stereotyping, prejudice, and acts of discrimination that serve to exercise power over others (Clement, Schauman, Graham, Maggioni et al., 2015). However, stigma is not the attribute in itself that marks one as the other; instead it is the stigma theory, the narrative at play that describes why the attribute discredits the bearer. Several distinct types of stigma have been identified, such as public stigma, self-stigma, and institutional stigma (Haugen, McCrillis, Smid, & Nijdam, 2017). Arguably, the most damaging type of stigma is self-stigma, rooted in processes of internalization (Merton, 1948, 1968). Self-stigma occurs when individuals internalize stigmatizing views, and can result in a downward spiral of self-imposed isolation, low self-esteem, and poor self-efficacy that only furthers self-stigma (Corrigan & Rao, 2012). It is one of the most frequently identified barriers to mental health care (Corrigan, Druss, & Perlick, 2014; Haugen et al., 2017) and has been linked to the "why try" effect, which interferes with life goal achievement, produces diminished self-esteem, and creates feelings of being "less worthy" (Clement et al., 2015). PSP experiencing perceived or real lack of recognition for their public safety role, particularly if recognition is desired, can be stigmatized and can experience inhibited access to supports—an injustice—even to the detriment of their wellbeing. Such practices can reinforce various forms of stigma (Goffman, 1963). The internalized lack of recognition may also be tied to insufficient validation for the trauma felt by PSP in support roles, which can underpin self-stigma by driving feelings of having their experiences minimalized or that they are unworthy of treatment or support.

In a systematic review of qualitative and quantitative studies, self-stigma or internalized stigma was found to have a consistently

negative association with help- or treatment-seeking behaviour (Clement et al., 2015). Specifically, statistical modelling of the relationship between stigma and help-seeking behaviours reveals that people avoid treatment due to the external stigma of seeking treatment, having a mental illness diagnosis, feelings of shame and embarrassment informed by self-stigma, and anticipation of discrimination (Clement et al., 2015). Consistent with Clement and colleagues (2015), Haugen and colleagues' (2017) review and meta-analysis of mental health stigma and barriers to mental health care evidenced a significant portion of PSP population identify stigma as a barrier to seeking treatment for a mental illness. The top three issues identified were: a fear of services not being confidential, that seeking help would have a negative impact on their career, and feelings of judgment by coworkers and leadership (Haugen et al., 2017). Delays in seeking help for mental health issues result in delayed mental health treatment, and, therefore, the increased risk of the negative impact of mental illness on an individual's work, family, and personal wellbeing (Ricciardelli, Carleton, Mooney, & Cramm, 2018). Negative impacts can be substantial, with death by suicide being a tragic manifestation of stigma that may be a significant risk for PSP (see Carleton, Afifi, Turner, LeBouthillier, Duranceau et al., 2017).

### *Current Study*

An assessment of PSP mental illness (Carleton, Afifi, Turner, Taillieu, Duranceau et al., 2017) underscores that mental health problems exist among PSP at substantial rates; specifically, 44.5 percent of PSP respondents screened positive or said they had been diagnosed with one or more mental disorders, such as anxiety disorders, PTSD, depressive disorders, and alcohol abuse. In addition, 10 percent of the same study participants reported having thoughts of suicide in the past 12 months, and 15 individuals (0.3 percent) reported attempting suicide in the past 12 months (Carleton, Afifi, Turner, LeBouthillier, Duranceau et al., 2017). The barriers to treatment seeking for the general PSP population were expressed as significant, with PSP reporting feeling unrecognized, uncared about,

and fearful that health seeking would negatively impact their careers (Ricciardelli, Carleton, Mooney, & Cramm, 2018; Ricciardelli, Carleton, Cramm, & Groll, 2018).

Collectively, the available results demonstrate some level of untreated or undertreated mental health issues in PSP, which may be intensified for PSP who feel invalidated or undervalued. Our intention in the current exploratory study is to shed light on the experiences of those beyond the traditional frontlines, toward recognizing and addressing their unique and poorly understood mental health needs, which we contextualize as impacting access to justice for these PSP. We interpret justice as access to the support to which all persons involved in keeping the public safe should be entitled and we recognize the wraparound effects of compromised PSP wellbeing, both in the lives of PSP and the experience of citizens who come into contact with said PSP within systems of public safety.

## Methods

An online survey was administered to PSP from September 1, 2016, to January 31, 2017 (Carleton, Afifi, Turner, Taillieu, Duranceau, et al., 2017). Available in both English and French, the survey was comprised of both quantitative and qualitative components and looked to establish prevalence rates of mental disorders and occupational stress injuries among PSP. The 492-item survey included validated self-report screening measures that serve as indicators of potentially clinically significant symptom clusters (e.g., PTSD Check List 5, 9-item Patient Health Questionnaire, the PD Symptoms Severity Scale, Social Interaction Phobia Scale, and the Alcohol Use Disorders Identification Test), as well as established scales measuring occupational stress, experiences, sleep patterns, chronic pain, and other indicators of health (for additional study information see Carleton et al., 2017; Carleton et al., 2018).[1] Ethical

[1] For more fulsome methodological details regarding the larger study and survey, including response rate, questions, and recruitment processes, please see Carleton et al., 2017 and Carleton et al., 2018.

clearance was granted by the University of Regina Institutional Research Ethics Board (#2016-107).

Study participants broadly included paramedics (e.g., emergency medical services personnel, emergency medical technicians), firefighters (e.g., professional, volunteer, full-time, part-time), communication specialists (e.g., emergency call centre operators, dispatchers), police (e.g., municipal, provincial, federal, First Nations, border services), and correctional service workers (e.g., institutional, community), in addition to the civilian and uniformed persons who support PSP (Carleton, Afifi, Turner, Taillieu, Duranceau et al., 2017). Diverse strategies were used to optimize recruitment. Organizations representing these groups, including the Canadian Association of Chiefs of Police, the Canadian Association of Fire Chiefs, the Paramedic Association of Canada, and Correctional Service Canada, helped to disseminate information about the study to their members; individuals could consent to participate online and be directed to the survey. In addition, a public service–type of announcement, featuring the Canadian Minister of Public Safety and Emergency Preparedness speaking to the importance of participating, was circulated (https://youtu.be/lx_2MM2EYi8). Unions and advocacy groups also aided in the dissemination. The research was not sponsored by any organization, nor did any organization have official involvement in the research beyond knowledge user capacity (see https://www.cipsrt-icrtsp.ca/).

Participants took, on average, approximately 90 minutes to complete the survey and were not given an honorarium for participating (Carleton et al., 2018). The current study examined responses to the following open-ended item: “If you have any additional information you would like to provide or additional feedback, please feel free to do so below.”

### *Sample*

Recruitment efforts resulted in 8,520 PSP participants answering at least the first question, which inquired about PSP role (i.e., "Please indicate which category of First Responders or other Public Safety Personnel you feel best describes your current occupation"), though not all participants completed the entire survey. Despite the considerable time required to complete the quantitative components of the survey, 828 participants voluntarily responded to this open-ended item, generating substantial amounts of qualitative data. Despite best efforts, participants could not be clearly categorized into "frontline" versus "beyond the frontline" employees because their work in public safety roles is dynamic and versatile; in many occupations, PSP can be deployed at times and not deployed at others. PSP can also be deployed but not actually at the scene of the incident (e.g., driving the ambulance or truck; talking on the phone without being physically present). In addition, the concept of what constitutes the frontline appears increasingly contentious. For example, 911 operators are often considered "beyond the frontline" yet are listening to complete destress on the phone before a PSP physically arrives on scene. Thus, how is one to argue that 911 operators are or are not on the frontline? Among respondents, some wrote about their experiences onsite once deployed to an incident, while in other cases participants described incidents experienced by colleagues and expressed gratitude that they were not on shift; it is the latter participants who are included in this study, as well as those who are not deployed to a scene physically. As such, when creating the sample we did exclude responses that were rooted in experiences gained onsite at an incident—the traditional conceptualization of the frontline. Persons working behind this traditional frontline, such as communication specialists, transcription specialists, non-deployed PSP, and those who read or hear about, listen to, or watch recordings of an incident, or who are left to worry about those deployed, constitute our sample. These individuals hold positions that are central to ensuring public safety; however, they are too often perceived as peripheral to frontline roles.

There were 269 female and 556 male participants, and 3 who declined to report their sex. Most participants were geographically located in the Western provinces (i.e., British Columbia, Alberta, Saskatchewan, and Manitoba), about a quarter in Ontario, and the remainder in Quebec and the Atlantic provinces (see Table 1).

**Table 1: Number of PSP participants by region of employment**

| **Region** | **Total** [a] |
|---|---|
| Western [b] | 433 |
| Ontario | 244 |
| Quebec | 48 |
| Atlantic/Eastern [c] | 97 |
| Outside of Canada | 3 |

*a Some participants reported working in more than one region.*

*b MB 23; BC 140; AB 154; SK 112; Western (not specified) 4*

*c NB 24; NL 15; NS 44; NT 4; NU 1; PEI 4; YK 3; Eastern (not specified) 2*

A range of occupational groups were represented within the sample, with the largest representation coming from RCMP, paramedicine, municipal police, firefighters, and operational correctional workers. Other groups with smaller representation included provincial police, communication specialists, and Canadian Border Services (see Table 2).

**Table 2: Number of PSP participants by occupation**

| PSP Occupational Group | Total |
|---|---|
| Call centre dispatch/operator | 26 |
| Canadian Border Services | 10 |
| Other (coast guard, coroner, nursing, administrative, USJE) | 12 |
| Correctional work, administrative | 21 |
| Correctional work, operational | 92 |
| Pre-medicine (paramedic, EMR, EMT) | 146 |
| Firefighter | 103 |
| Other fire (fire/paramedic, volunteer, search and rescue) | 25 |
| Municipal police | 142 |
| Provincial police | 30 |
| RCMP | 208 |
| Other police (transit, special constable) | 5 |
| Not specified | 8 |

## *Analysis*

The qualitative data embedded within the full demographic and quantitative data were extracted through NVivo's Autocode function, which allows us to transform each study participant into a unique "case." The Autocode function can then code each respondent's qualitative responses as separate "Nodes" that allow us to organize common material. The "Attributes" function enables us to maintain connection to the demographic information for each case. Only data for participants who selected "For any part of the research, including quoting what I wrote" as a response to "Please let us know how we can use any additional information and feedback that you have provided in the open text fields" will be represented through direct quotations.

We used a semi-grounded approach to qualitative coding (Glaser & Strauss, 1967). The coding scheme was developed inductively, with the coder reading the first 100 responses and cataloguing themes in an emergent fashion. New themes were developed as they became evident, refining the coding scheme. There were six central emergent themes: coping, mental health resources, PSP frontline support experiences, stressors, trauma, and workplace. In the current study, we focus on the central theme of PSP frontline support experiences, or "beyond the frontlines," in refining the coding scheme, which we then used to re-code previously coded data. This "axial coding" process (Saldana, 2015) allows the coder to disaggregate, amalgamate, and reclassify certain nodes to produce a cohesive categorization of the data within the open-text responses. The coder becomes immersed in the data, reading and re-reading the responses and axially coding to fully develop an exhaustive list of themes. Two coders coded and categorized the data until all were reliably coded. Disagreement in coding was often resolved through dialogue between coders and the lead author. However, if necessary, discussion with members of the larger research team informed resolution. Quotations represent the verbatim responses from participants. In order to maintain anonymity, potentially identifying text has been replaced with "[TEXT]"; to further protect participants' identities, we report only gender and occupational category.

## Results

Several different public safety role types beyond the commonly considered firefighters, paramedics, and police were identified; for example, those operating within occupations such as communications/dispatch, administrative roles, case managers, support staff within correctional facilities, border services, and civilian police positions, among others. Reflecting on open-text responses provided by individuals employed in all such positions, two themes emerged: 1) many report a lack of acknowledgement, validation, or recognition from the public, their families, their friends, and their organizations that they, too, suffer real trauma as a result of their jobs; and 2) many express despair that their situation cannot

improve. Collectively, the experiences of these PSP result in nuanced and explicit barriers for help seeking, which we argue suggests there remains much injustice in how diverse PSP are treated in society and their associated access to much needed treatment, intervention, or even preventative care.

### *Unrecognized within the PSP Organizations*

For some PSP, their role within the organization was equated to a specific status, one that extends beyond positioning on a rank-oriented status hierarchy, such as the absence of or difference in uniform, or a workspace or location (e.g., they may be off site and physically segregated from others who are deployed during calls for service). While some PSP may become the public face of high-profile events and potentially enjoy the social benefits associated with serving a public in need or the status tied to a recognized uniform, there are critical PSP who serve outside the public eye. PSP operating outside of the public eye often feel that their families and the communities they serve do not fully comprehend the nature of their work and the resulting occupational and social responsibilities. A respondent in a PSP support role shared:

> With regards to the Alberta Wildfires of 2016, there has been much care to acknowledge those that went to the frontline. What has been missed is the recognition of those that stayed behind and took on the extra duties, and in fact in a lot of cases, much more duties than those that were deployed. Those that were deployed have been publicly praised, and have received recognition items. Those that had to take on the extra work back at home received no physical recognition, and very little verbal recognition. (Police Services, Male)

The participant's words here show their perception of the differential recognition of PSP who are on the frontlines versus those who remain behind the scenes providing support, including those who must shoulder the responsibilities of those deployed. Included here are also

PSP who once held PSP roles on the traditional frontline who, for a variety of reasons, no longer qualify for deployment, and, rather than being terminated or put on leave, have been transitioned to non-operational support roles in their organization. In essence, thematic analyses show that the colleagues who make it possible for others to be deployed safely tend to feel their contributions are unrecognized. This disparity can breed feelings of inferiority and self-doubt among those who are not deployed, leaving them feeling unrecognized for their efforts within the system.

Moreover, distance from the frontline does not necessarily protect the psychological health of those working to support those deployed. For example, "hidden" PSP working in telecommunication support bear a responsibility for the safety of those who call for help, as well as their deployed colleagues. A PSP explained that "many of those civilian members [in communications/dispatch] have to work on call by themselves, take calls in the middle of the night and on weekends then show up for work in the morning. It is a big responsibility because if an officer…can't communicate via the radio system it becomes an officer safety issue" (Civilian Member, Police Service, Male). This participant's words reveal the responsibility for the safety of staff and the public that comes with dispatch roles.

Notwithstanding, with this responsibility for public safety comes an array of interconnections with incidents as they unfold, including hearing the incident and its aftermath, as well as fear, pain, terror, and trauma in the voice of callers, often without any context. A communication specialist explained: "We constantly deal with screams in our ears, crying, sounds of horror, fear, death, suicides, assaults, robberies, murders, info being thrown our way, we handle such chaos with professionalism and empathy. If we make [one] mistake it could [cost] someone their life" (Call Centre Dispatcher, Female). The personal difficulty of hearing potentially traumatic events, as she describes, is only one aspect of the occupation, compounded by the perception of their experiences being devalued because they do not "necessarily 'see' the trauma but still experience it" (Civilian Member, Police Service, Female).

Some PSP explain that their work can create ongoing exposure to traumatic material yet—because they either do not hold the title of "police" or "firefighter" or are no longer in roles where they are likely to be first on the scene of, or even deployed to, an incident—they feel their exposure (and the possible consequences on their wellbeing) is ignored within the larger organizations of public safety. To this end, a female member of a police service who no longer works on the traditional frontline noted that: "Frontline police see things once or twice. Analysts and other support admin see the file contents, images, videos, sounds, over and over again to complete their work (sometimes hundreds of times). There needs to be an acknowledgement of the impact this can have on these people. PTSD is not just a police officer's illness" (Police Services, Female). The words of this officer show that she, echoing others, feels her experiences are not recognized as traumatic or potentiality traumatic. The expression that "PTSD is not just a police officer's illness" explicitly reinforces the potentiality for self-stigma experienced by PSP who experience trauma but whose jobs do not involve being deployed first to the scene of an incident. The desire to have their mental health needs recognized and validated to the same extent as that of "first responders" was undeniable across survey responses. Many used the opportunity to respond to the survey to remind us, as researchers, that they too are fundamental for public safety in their roles and need mental health support. For example, a civilian member of a police service, echoing others, wrote:

> Please be aware that it is not only dispatchers and officers that experience stress in the workplace that result in OSIs. There are many civilian employees of the [police service] that have stressful jobs that have a direct impact on members and dispatchers and other public safety… I find that these surveys, especially at the beginning, tend to put more emphasis on the OCC operators and regular members. Usually the CM's [civilian members] are at the end of the employee classification question under "other". It makes CM's feel like their jobs are not as important or could even

> be stressful enough to cause an OSI or mental health issue. (Civilian Member, Police Services, Male)

This civilian member's words clearly express that he feels undervalued. This feeling of being unrecognized, unacknowledged, and undervalued is further intensified for PSP who are emotionally invested in their job—keeping society safe. Continuing reinforcement of the absent validation can be "stressful enough to cause an OSI or mental health issues," thus reconciling their occupational position with their mental health needs.

PSP working behind the frontlines feel they either do not have access to mental health services related to traumatic stress or should not expect to experience mental health issues related to their occupational responsibilities. PSP report feeling that the possibility that they could develop PTSD has, seemingly erroneously, been considered unlikely within the larger public safety organizations. Specifically, many participants reported feeling their organizations do not structurally acknowledge this potentiality for non-deployed PSP and thus do not offer training and education, or create a culture for mental health awareness, prevention, and intervention. Such realities (or perceptions) create barriers to PSP in said roles recognizing their own mental health issues. One male respondent reflected: "I was suffering silently and not knowing I had PTSD." Another remarked: "If I had been aware of the reasons for my symptoms, I would have been able to seek help years earlier than I did" (Male). The words of our PSP participants showcase their ability to recognize their disintegrating mental health early on, but indicate they may not recognize the link between their work and their mental health because of the types of potentially traumatic event exposures.

In addition, many PSP reported that persistent job stressors and strains become increasingly normalized, which mask the presence of symptoms that might otherwise indicate their mental health needs. A male officer commented:

> I believe a lot of people including myself have challenges in their work and personal life but do not realize the stress or

> the physiological/psychological strain that they are under. The feelings or conditions that are being endured may be part of our "normal life" when in reality it may be a symptom of an undiscovered condition. The amount of and the effects of stress are underestimated and everyone in this field of work especially, need to be cognizant of their own bodies and minds and take the appropriate steps to help themselves, no matter what stage they are under. (Police Services, Male)

This participant explains that many symptoms of distress go unnoticed, which then places responsibility on PSP for recognizing their own mental health needs. The participant may be engaging in a sort of "blaming the victim" process that fails to recognize the shared individual and organizational responsibilities for wellbeing. His thoughts suggest a substantial internalization of the stigma tied to help seeking and mental health more broadly. A workplace issue (e.g., work making one ill over time) is transformed into and then reinforced as a individual issues (e.g., one failing to understand their health) instead of being a social issue. The fact that indirect exposure to potentially traumatic events could, and often will, affect the mental health of PSP working behind the traditional frontlines while remaining stigmatized makes the practice of coming to terms with the events more convoluted and difficult to navigate—a struggle expressed by many respondents. A PSP shared their experience of overcoming their sense of the stigma of disclosing mental health needs:

> I decided not to hide and talk to my family, colleagues and trainees/students. My goal is to make people comfortable with these terms, that they realize that it really exists and that it is treated. I have noticed over time, thanks to the confidences of these, that many people in the field are, at certain different levels, suffering from post-traumatic stress but that the vast majority do not speak about it. They prefer to forget/bury this pain rather than learn to live with it and face this ordeal.

This PSP's words show that the anguish underpinning mental illness is not limited to how it impacts their wellbeing but is also rooted in barriers that make help seeking difficult and, also, make people apprehensive about acknowledging they may have a mental illness. This emotional strain is only exacerbated among PSP who may feel that because their occupational role is hidden from the public eye (i.e., not on the frontlines), their organization does not offer them sufficient or any mental health supports—beyond failing to recognize they require such support. Thus, many PSP feel their mental health concerns fail to be validated within the system, and, even if they are accepted, the services are not there to help:

> While it is important to recognize the stresses experienced by frontline employees, it does not mean that support staff are unaffected. The files we handle, the details we hear, dealing with stressed clientele and coworkers and our requirements to 'keep it all at work' add up to make for a long term, accumulation of stress. On top of that, many programs completely overlook support staff or are 'cut to fit' or dumbed down, so they are not as comprehensive. We are never forgotten when a new duty needs to be assigned, but we fall off the radar for health and mental wellness. (Public Servant, Police Services, Did not disclose gender)

As evidenced in the participant's statement, PSP in select roles may feel "forgotten" in debriefing or other activities aimed at health and mental wellness, again reinforcing their feeling of being undervalued. Many describe working in a public safety "system" that is currently unequipped to anticipate the impacts of potentially traumatic events for those not deployed into the field: "When we take horrible calls we are often overlooked in a debriefing held afterwards" (Dispatch, Female). They feel ignored and, more detrimentally, some report negative and harmful experiences when seeking recognition for their mental health injuries or using services to address them. Here, a PSP, working as a civilian in a police service, noted: "Most employees in my job have PTSD but get ridiculed for being labelled 'attention seeker' or 'making it all up'" (Police Services, Female). In essence,

the sentiment here is that if PSP working behind the scenes develop mental health issues over an incident, they may feel as though they cannot seek help without losing their credibility because they were not directly involved in the incident as frontline workers. Such experiences, PSP report, are further reinforced in the broader community, including by family members, who may similarly lack an appreciation for their indirect experiences. Quite forcefully, another civilian member of a police service explained that "then you realize how few people understand what you go through, what you have lost, to make this world a better safer place, but you are not a first responder so it doesn't really matter" (Civilian, Police Service, Male). Thus, although PSP are repeatedly indirectly or directly exposed to potentially traumatic events, because they are behind the traditional frontlines, they feel that the public safety systems, as well as the larger community and colleagues in deployed roles, fail to appreciate their ongoing risk and the potential consequences to their psychological health.

### *Despair That Their Situation Will Not Improve*

PSP who work "behind the frontlines" expressed much concern in their comments about their sense of isolation, even alienation, in their mental health struggles. They reported feeling "alone": "as of now there are many of us that feel that we are required to deal with our situations alone" (Firefighter, Male). Perhaps a symptom of their current state of wellbeing or a consequence of years of witnessing the struggles of others with mental health needs, participants disclosed a sense of isolation in their mental health experiences and an even broader sense of despair that there was no plausible avenue through which their situation could improve. For example, having left work due to ongoing mental health issues, a former frontline PSP emphatically wrote: "I left my job a year short of retirement after almost 30 years because I was so obviously fucked up. No one gave a shit" (Police Services, Male). This PSP's blunt words express the feelings of being unrecognized or undervalued as a person struggling within the greater public safety paradigm—a further debilitating

reality for one already trying to navigate the difficulties of mental disorders.

Respondents consistently asserted a perception of their public safety organization as being disingenuous in their attempts to address the health of their workforce, those in direct operational positions, and at the broader level of those in rather marginalized or "outsider" PSP roles. For example, a male with experience in paramedicine stated that organizations "only care in the boardrooms and memos." This participant, like many others, felt that organizations simply pay lip service to the mental health concerns of non-deployed PSP, rather than actually try to improve their access to services or even receive training geared toward assisting with mental health. Some PSP did recognize that "management may have good intentions" (Police Services, Male) and want to meet the mental health needs of their employees. The impossible problem, however, seems to be the perceived inability of management, even those who have best intentions, to address the needs of their employees in ways that employees feel are meaningful. Not surprisingly, PSP voiced concerns about their organization's ability to adapt to the many needs faced by those within their public safety service. Here, some felt that the institutional culture was too "toxic," and in consequence, even programs developed and implemented with the best of intentions failed to make change or be effective. For example, a PSP wrote: "There is no point rolling out mental health strategy for employees when a broken, toxic and [under-resourced] work place has become normalized by Government and executive management" (Police Services, Male). As his words reveal, an expression of perceived futility of efforts to redress the situation was common. In essence, this consistent sense that "nothing will change" (Paramedicine, Male) remained prevalent—an injustice tied to the harm of deep patterns of the past inevitably shaping the future:

> I have very little faith that my employer will do anything more than give verbal consent to the validity of this research. The reality in the field is so far removed from what is politically accepted as correct in this present day. I have

> received very little support from supervisors and coworkers because everyone is just trying to survive themselves and they fall back on old belief systems and established behaviors. (Police Services, Female)

Here, her statement underscores the sense of pervasive brokenness among those working within public safety organizations, regardless of their position or role.

**Discussion**

Identifying and addressing mental health issues experienced by any PSP group are relatively new initiatives within Canada. Thus, it is not surprising that those whose trauma exposure and mental health risk are not as obvious within the PSP organizations and the broader PSP community have not been well defined or addressed. Indeed, when employees feel that their organization considers certain PSP as not requiring certain resources (implicitly or explicitly), the needs of PSP are even less likely to be understood, recognized, or addressed by others. Emergent themes in our data suggest that PSP working behind the frontlines feel they are not "supposed" to experience mental illness and/or that the trauma they suffer is minimalized, which, accordingly, delays the process of recognizing their illness and what is causing it. In addition, once recognized, many report feeling excluded from support services because of their role. The metaphoric "line" that separates the traditional frontline PSP who respond to an incident in person and those behind the traditional frontline creates perceptions of disparity and differential access to healthcare supports and resources; those with the most distal exposures to trauma may also be the least able to access services and supports. The fact that access to services and support for those working within public safety appears or is felt by PSP to be mediated, unintentionally perhaps, by occupational position is an injustice in access. This injustice is further evidenced in the pervasive stigma that creates internal and external barriers to help seeking for select PSP, deepening a sense of alienation and despair for their futures at work and in terms of health.

Those working behind the traditional frontline may feel marginalized and question if they are deserving, worthy, or credible in their experience of potentially traumatic events through operational duties or organizational stressors. This is, again, tied to participants reporting feeling that the trauma they face in their work is neither validated nor recognized, and subsequently minimalized because their trauma is less visible than that of traditionally frontline PSP. This is consistent with the dearth of research and programming available for behind-the-frontlines PSP relative to those operationally deployed (Coxon et al., 2016; Golding et al., 2017; Shakespeare-Finch et al., 2015; Steinkopf et al., 2018).

Stigma, including self-stigma, remains a powerful deterrent for many in need of mental health treatment, regardless of one's professional role (see Ricciardelli et al., 2018). However, in help-providing professions such as those of PSP, there are additional cultural barriers related to recognizing personal mental health issues. As such, admitting those mental health issues has become a personal reality that cannot be willed away, representing a barrier to seeking mental health services. For those working behind the traditional frontlines, there is an additional layer of barriers rooted in their internationalization of the sense that their experience of trauma is less worthy than that of frontline employees. This sense further compounds their struggles and places them at further risk—only exasperating negative experiences and mental distress. Fear related to being seen as "playing the system" may be overwhelming and increasingly constrain action towards recovery (Ricciardelli et al., 2018). All these factors converge, reinforcing the injustice of their sense of despair and inability to change one's situation. The consequence here includes putting PSP with hidden mental health risk in a state of hopelessness, which may increase the risk for completed suicide (Huen, Ip, Ho, & Yip, 2015); certainly, the statistics regarding PSP suicidal behaviours suggest an elevated level of concern is warranted (Carleton, Afifi, Turner, LeBouthillier, Duranceau et al., 2017).

### *Limitations and Future Work*

Our exploratory work is limited in that, as is common when considering qualitative data, generalizability should be interpreted with caution. In the context of this study, only the data of those who opted to volunteer responses to a general open-ended request for comments could be analyzed. Despite this limitation, and the inability to follow up with our anonymous participants, the results accurately represent the perspectives of participants who took the time to offer them even after working through the lengthy surveys. Nonetheless, we urge future researchers to take note of the additional organizational and cultural risk factors and create the needed and more targeted education, early intervention, and secondary prevention that include the unique experiences of those working behind the frontlines. Inclusion of all PSP in training around mental health, self-care, and resilience is also recommended, both in practice and as an area of study, in addition to renewed strategies aimed at recognizing the work of those whose efforts are hidden from plain view yet so instrumental to the success of the team as a whole (Weibel et al., 2003). Finally, future work with legislation and policies, alongside those who work to develop them, is necessary to ensure that all policy and legislation developed is inclusive of those at risk and those who require access to supports because of their service to maintain the safety of the community (see Ricciardelli & Hall, 2018; Hall, Ricciardelli et al., 2019). Organization-level interventions to promote cultural change and inclusivity of all PSP groups are, and will continue to be, paramount to reduce stigma and encourage help-seeking behaviours for those in need. Stigma related to concerns that individuals are "playing the system" to access the benefits and supports related to an OSI (Ricciardelli et al., 2018) should be considered in the development of these strategies.

Our study also creates new questions for researchers to consider within the field broadly, including what other occupational groups should be included as PSP because they promote community safety in diverse ways and they are regularly exposed to potentially traumatic

events that go largely unrecognized.[2] Moreover, are there similarities and differences, including in access to mental health resources and services, between occupational categories that are tasked to maintain public safety and security versus those that are not, regardless of the ongoing exposure to trauma? How can we be strategic in developing the field so that different groups feel they have equitable and just access to resources? And how do such realities impact access to justice for those encountering affected PSP or the PSP who feel their experiences and needs, due to their occupation, are not validated or recognized? Nonetheless, expansion of the definition of PSP will continue to strain already limited resources, particularly within institutions that are not structured yet to provide education, early intervention, and secondary prevention to the traditional frontline responders, let alone to those who feel they have yet to be professionally deemed as requiring those resources and supports.

Overall, research on the mental health of PSP has grown over recent years, but its focus has been biased towards those PSP who operate within frontline deployments rather than those who support operations behind the traditional frontlines. This study reveals new insights into the perceptions of PSP whose trauma exposure and mental health risks are often obscured from community awareness and whose experiences are felt to be considered, organizationally, secondary to those working on the frontlines.

[2] Recognizing that participants did express feeling undervalued by researchers, although beyond the scope of the current study, we encourage future researchers to explore the interactions between PSP and researchers and try to unpack why PSP feel undervalued.

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