We Are Asking The Wrong Question

Why the First Responder Mental Health Field Has a Knowledge Surplus and an Accountability Deficit

Vince Savoia | 2026 | Position Paper

Abstract

Over the past ten years, extensive research has confirmed that first responders face Operational Stress Injuries at rates significantly higher than the general population. The field has responded with clinical interventions, resilience training, peer support programs, and national standards. However, there is almost no evidence that any of these efforts are leading to lasting, measurable culture change within first responder organizations.

This paper argues that the field has misunderstood the core issue. Operational Stress Injuries are not preventable; they are an expected consequence of the work performed by first responders. The key question is not how to prevent injury but whether organizations are designed to lessen its effects. Organizational mitigation involves creating systems, leadership practices, and cultural environments that reduce harm after exposure and foster recovery over time. It is distinct from individual resiliency training and is largely absent from current research agendas.

Until this situation changes, interventions will keep underperforming, resources will keep being wasted, and first responders will keep bearing an organizational burden that no level of personal resilience can handle.

1. The Premise We Keep Getting Wrong

There is something worth examining in the language the field has established around first responder mental health. We talk about prevention. We create prevention plans, prevention frameworks, and prevention-focused standards. The word suggests that with the right intervention, at the right time, the injury can be avoided.

That framing is, at best, incomplete. And most people working in this field have quietly known it for years.

First responders witness death, absorb trauma, and operate in conditions of ongoing moral complexity as part of their professional routine. A paramedic with a full career will attend to more traumatic scenes in a single month than most people experience in a lifetime. These injuries are not unusual. They are an occupational reality. The question was never whether they would happen. The real concern is what happens to the person when they do, and whether the organization around them is set up to support them.

> ***Prevention is a misnomer. Mitigation is the real focus. The field has spent a decade addressing the wrong issue.***

The distinction matters because it influences everything that follows. If the aim is prevention, we concentrate on resilience training, identifying vulnerabilities, and teaching coping skills, all centred on the individual. If the aim is mitigation, we pose a different question: Will the organization support their recovery or impede it?

Organizational mitigation, defined here as the sustained effort to foster leadership behaviours, cultural conditions, and structural supports that lessen harm after exposure and aid recovery over time, is not a program. It is not a peer support team or a wellness policy. It is the environment in which all of those elements either succeed or fail. The research has scarcely begun to examine it. This paper contends it must.

2. What The Research Is — And Is Not — Doing

The evidence base on first responder mental health has grown substantially over the last decade. Canada's landmark national study (Carleton et al., 2018) found that 44.5% of public safety personnel tested positive for one or more mental health disorders, more than four times the rate found in the general population. A 2025 RAND Corporation review confirmed that stigma, organizational barriers, and fear of career repercussions remain the main obstacles to seeking care, and it called for research that goes beyond increasing knowledge to examine real outcomes. A Public Services Health and Safety Association risk assessment in Ontario identified PTSD as the leading occupational hazard for paramedics, surpassing physical dangers such as traffic exposure and workplace violence.

The problem is not under-researched. It is, arguably, over-confirmed. The current research landscape tends to repeat three main patterns.

- Verifying the existence and extent of Operational Stress Injuries among first responder populations

- Testing clinical interventions: psychotherapy, residential programs, digital mental health tools, at the individual level
- Creating implementation guidelines, best practice frameworks, and program assessments

What it does not do is examine whether organizational culture genuinely changes after a psychological health and safety standard is adopted. There is no long-term research on what happens within a first responder organisation one, three, or five years after the standard is implemented. There are no widely accepted metrics for measuring ongoing culture change. There is no accountability framework for organisations that adopt a standard as a compliance measure and then do very little.

> **Research gap:** *A 2023 study found that most research focuses on specific program outcomes rather than the wider context of policies and implementation. Without this broader understanding, policymakers and leaders may lack the insights needed for meaningful change. That gap remains largely unaddressed.*

Filling this gap requires a different approach to research than what the field has been doing, and a willingness to ask tougher questions about organizations, not just individuals.

3. The Compliance Checkbox and Its Consequences

When organizations decide to tackle first responder mental health, their approach often follows a familiar pattern. They draft a policy. They form a peer support team. They deliver a training program. They adopt a standard. The necessary steps are ticked off. Leadership claims the issue is resolved and moves on.

None of this constitutes genuine culture change. Much of it is liability management masked as care.

Organizations undertaking this are not acting in bad faith. Many genuinely believe that launching a program means solving a problem. What they haven't been told, because the research hasn't made it clear enough, is that a program without sincere organizational commitment is rarely neutral. It can actively worsen the situation.

> ***A hollow implementation doesn’t just fail; it also erodes the trust that any mitigation system relies on. First responders can tell right away when the commitment is genuine.***

First responders have a strong sense of institutional sincerity. They have built their careers in high-pressure environments where the difference between words and truth can be a matter of life or death. They apply that same awareness to organizational behaviour. When a peer support program is introduced without proper selection, training, supervision, or protected time, and when the team is formed but the culture remains unchanged, the message conveyed is not "we care about you," but rather "we needed to have a program to say we did."

That message does not come across as neutral. It confirms that the organization cannot be trusted, and an organization that cannot be trusted is not one a first responder will turn to when they are struggling.

A Case in Point: When Good Intentions Cause Harm

Consider an organization genuinely committed to developing a peer support program. They recruited volunteers, provided training, and launched the team with visible leadership support. The issue was with the selection criteria. Misunderstanding what "lived experience" means in peer support, they selected peers specifically because those individuals had experienced an operational stress injury themselves.

The goal was to promote relatability. The outcome was predictable to anyone familiar with peer support systems. Some peer supporters experienced re-traumatization while in their roles. They had not fully recovered enough to support others' pain without absorbing it themselves. The program unintentionally caused harm to those it aimed to assist.

Management, faced with the fallout, completely cancelled the program.

This isn’t a tale about bad people. It’s about what happens when an organization acts quickly, without sufficient research, proper program design, or an understanding of the difference between having lived experience and being prepared to support others through it. The checkbox was ticked. The program existed. And those involved paid the price.

The research community has yet to develop tools to measure how frequently this occurs, the circumstances surrounding it, and which organizational decisions contributed to the failure. That shortcoming is itself part of the problem.

4. The Hierarchy of Mitigation — And Why The Field Has It Inverted

The dominant model in current research emphasizes individual resilience as the primary strategy for mitigation. It involves strengthening the person, training them to recognize stress responses, providing coping tools, and connecting them to clinical support when symptoms emerge. This approach is not incorrect; however, it is inadequate, and without organizational change, it risks becoming more problematic in shifting accountability away from the organization and onto the individual.

Consider the logic behind individual resilience as a primary response. If the intervention targets the person, the underlying assumption is that the individual is the main variable. When they sustain a debilitating injury, cannot return to work, or die by suicide, the failure is often seen as placed on them. They did not develop enough resilience. They did not utilize the tools. They did not seek help in time.

This framing can be clinically insufficient, and when the organization itself causes harm, it raises serious ethical concerns.

> ***You can teach someone resilience; however, you cannot teach them to be resilient enough to withstand an organization designed to break them.***

Organizational mitigation is not a substitute for individual mitigation; it provides the foundation. Individual mitigation strategies, such as peer support, clinical access, and resilience training, can only be effective within organizations that have established the psychological safety needed to use them. Without that safety, the tools are available but inaccessible. The peer supporter is present but cannot be trusted. The clinical service is funded but remains unused.

5. What Organizational Mitigation Actually Requires

Organizational mitigation is not just a program. It is an ongoing commitment demonstrated through leadership actions, resource distribution, and accountability frameworks, sustained over time, not a one-time announcement set aside afterward.

Drawing from four decades of hands-on field experience, the following are the most crucial conditions for effective organizational mitigation.

Genuine Leadership Commitment

This is not merely a policy statement or awareness campaign. It is leadership behaviour that consistently shows, through staffing, promotion, time, and financial decisions, that psychological health is a priority for the organization. First responders observe what leadership does, not just what it says. The commitment must be clear in how resources are allocated and in how leaders respond when a member seeks help. A chief who discusses mental health at an annual conference but ignores a supervisor penalising a member for taking a mental health day has not truly committed; they have only made an announcement.

The Vital Role of Middle Management

Senior leadership sets the direction. Middle managers ensure it takes hold. Supervisors, team leaders, and front-line managers are the first responders that daily interact with the workforce. They decide, in real time, whether a struggling member is met with curiosity or suspicion, support or pressure to return to duty before they are ready. In many organizations, they are also the least supported and least trained individuals in the mental health response chain.

No wellness program, regardless of how well designed, can replace a supervisory culture that views help-seeking as a sign of weakness. Developing middle management is crucial. It is the vital point where organizational change either succeeds or fails. Ricciardelli and colleagues' research showed that system-level stigma, the kind ingrained in supervisory responses and organizational culture, posed a more significant barrier to help-seeking than individual stigma among first responders themselves. If we are genuinely committed to changing the culture, it must include those who oversee the shifts.

Adequate and Secure Resourcing

Wellness programs that lack dedicated time, proper training, appropriate supervision, and clear role boundaries do not truly qualify as genuine wellness initiatives. They often represent an idea held by a single individual. Resources are not just a line item in a budget; they reflect the organization's core values. When an organization funds a wellness program but refuses to allocate protected hours, it has not genuinely committed to organizational wellness. Instead, it merely gives the appearance of support.

Structural Accountability

Organizations must be held accountable for the results of their implementation, not just the activities themselves. It's insufficient to ask whether a standard was adopted; the real question, which is often overlooked, is whether adoption has led to measurable changes in organizational culture, help-seeking behaviour, and outcomes over time. Without accountability frameworks, standards tend to become mere compliance exercises. The standard exists, the plan was filed, the review was passed, but on the organizational floor, very little changes.

Longitudinal Measurement

Culture change cannot be observed in a single snapshot. It requires long-term research involving the same organization and repeated measurements over years, using tools capable of detecting shifts in trust, help-seeking behaviour, supervisor responsiveness, and members' lived experiences. This type of research does not yet exist on a significant scale. Developing it is likely the field's most important gap.

6. The Research Agenda the Field Requires

The following questions are not currently being studied on a large scale. They should be.

- What is the nature of organizational culture in first responder services before and after implementing a psychological health and safety standard, assessed over a three to five-year period on a longitudinal timeline?
- Which leadership and supervisory behaviours are most closely linked to first responders' willingness to seek support? Which behaviours are most associated with ongoing avoidance?
- How much of the documented stigma in first responder organizations is inherent to professional culture, and how much is reproduced through organizational behaviour, especially at the supervisory level?
- When wellness programs fail or cause harm, what organizational conditions preceded the failure? What does an honest post-mortem reveal about the gap between policy and practice?
- What does meaningful accountability for implementing a psychological health and safety standard in an organization look like, and what mechanisms are necessary to make it a reality?

These questions cannot be answered through a clinical trial. They require organizational research, a longitudinal cohort design, and researchers willing to operate within the complex, hierarchical nature of first responder organizations. They also demand organizations willing to be studied honestly, which won't happen without trust, and will not happen at all if the field keeps treating research as something done to organizations rather than with them.

7. A Direct Message To Three Audiences

To Organizational Leadership

A standard adopted without genuine commitment is often worse than having no standard at all. It signals to your members that the organization's priority is managing liability rather than supporting them. First responders can see through programs that exist only on paper. If you are not prepared to adequately resource a psychological health and safety plan, oversee it carefully, and protect those who implement it, think twice before launching it. The harm caused by a superficial program can last beyond its budget cycle.

Genuine commitment differs from simple proclamation. It is demonstrated through how supervisors are trained and held accountable. It appears in protected time and sincere measurement. It shows in the response when a member comes forward, curiosity rather than suspicion, support rather than a managed return-to-duty. Without these elements, the program becomes merely decorative. And first responders will notice that.

To Researchers

The field has confirmed the issue. Continuing to verify it with larger samples and more advanced tools is no longer the most urgent task. The real challenge now is organizational and long-term: understanding whether and how culture shifts, what maintains those changes over time, and why well-intentioned programs sometimes fail or cause more harm than good. This work demands partnerships with organisations, an acceptance of complexity, and a willingness to publish findings that may unsettle funders and program developers.

The language used in the field also needs to be reviewed. Prevention is not the correct framework; mitigation is. Mitigation includes two types: individual and organizational, with organizational conditions forming the essential foundation. Continuing to use prevention terminology while assessing individual outcomes creates a mismatch that obscures what needs to be most understood.

To Policymakers

Standards without enforcement often become mere aspirations. Requiring organizations to create psychological health and safety plans without mandating proof of outcomes results in paperwork rather than meaningful change. If the federal and provincial frameworks for first responder mental health are to have a real impact, they need accountability measures, like outcome reporting, implementation reviews, and genuine consequences for organizations that simply check the box and move on.

The investment case is clear. Research shows that every dollar spent on proactive mental health support for first responders can save three dollars in healthcare and social services costs caused by untreated injuries. The real question isn't whether we can afford to fund this properly, but whether we are willing to establish the accountability systems that ensure the funding delivers its intended results.

Conclusion

We do not have a knowledge problem. The evidence that first responders are being harmed at rates that demand a serious organizational response is strong, consistent, and has been available for years. The research community has largely fulfilled its role.

What we face is an issue of implementation and accountability. Organizations often treat standards as mere checkboxes. Programs exist without the necessary organizational supports to succeed, and sometimes without adequate program design knowledge to ensure participant safety. The research field has extensively scrutinised individuals but has paid insufficient attention to organisations. First responders clearly recognise what superficial commitment looks like and have learned from experience not to trust it.

> ***The next decade of research must ask not whether the injury is real, we know it is, but whether organisations are capable of helping the people within them.***

That is a more complex question than simply measuring PTSD prevalence. It demands a different kind of courage from researchers, a different honesty from organizations, and a higher level of accountability from policymakers. However, it is the question that the field must now face.

Everything else is confirming what we already know.

About The Author

Vince Savoia is a Canadian public safety leader, consultant, and keynote speaker with over 40 years of experience in first-responder mental health, peer-support infrastructure, and trauma-informed leadership. He is the founder of Canada's first national charitable organization dedicated to the psychological health of first responders. He served on the CSA Z1003.1-18 committee, the national standard for psychological health and safety in the paramedic community. He has received a Meritorious Service Medal from the Governor General of Canada and holds a Graduate Certificate in Executive Coaching from Royal Roads University. He is based in Barrie, Ontario.