**Reducing misogyny and improving**

**sexual safety in the ambulance service**

**What we know**

October 2023

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# **Part A. What we know: The discovery phase**

## **Background**

There has been a significant focus on wellbeing and mental health within the ambulance service, with production of resources relevant to suicide prevention within the sector1. While staff mental health and wellbeing is an issue with many factors contributing to this, one aspect of ambulance culture that has recently come into focus is that related to sexual safety.

Sexual safety within the ambulance sector has been identified as a concern, following specific issues highlighted within Care Quality Commission (CQC) reports and subsequent media attention2–4. Specific factors, such as the nature of working within the ambulance service, having a hierarchical organisation, and having a workforce that until recently has been male dominated, are all thought to contribute to some potential issues with culture or attitudes5,6. Existing studies have suggested sexual harassment within the context of emergency service may be influenced or perpetuated through organisational cultures in which such behaviour is deemed acceptable, and the idea of a ‘rite of passage’which creates a groupthink mentality that normalises and creates a toxic culture within emergency service organizations5. There has been some suggestion in literature that ‘banter’behaviour is perceived as ‘harmless’ fun, thus relieving workplace stress. However, research also highlights that the presence of banter makes serious forms of sexual harassment more likely.

The subsequent impact of sexual harassment is significant, with risks to mental and physical health, as well as impacts on co-workers, organisational outcomes and potentially patient safety5.

This document outlines information gathered during the ‘discovery phase’ of the ‘Reducing misogyny and improving sexual safety in the ambulance sector’workstream which has informed the development of this workstream – table 1.

## **A note on language and terminology**

The project team recognises that there is a wide range of language and terminology that can be used in this area. It is important to educate all staff on the range of terminology – appendix 1.

All three documents adopt the phrase *‘*sexual safety’as agreed by stakeholders during the project – appendix 2. This phrase was deemed to be one used across, and recognised by, ambulance service employees whilst aligning with current legislation – the Equality Act (2010). Project stakeholders also agreed that ‘sexual safety’ supported the culture transformation needed at an individual and organisational level. Terminology and language presented in appendix one is also aligned to the [NHS England: Sexual Safety in the workplace: resources and support toolkit.](https://nhsengland.sharepoint.com/sites/thehub/Shared%20Documents/Forms/AllItems.aspx?id=%2Fsites%2Fthehub%2FShared%20Documents%2FHR%20and%20Organisational%20Development%2FSexual%20safety%20in%20the%20workplace%20resources%20and%20support%20%2D%20NHS%20England%2Epdf&parent=%2Fsites%2Fthehub%2FShared%20Documents%2FHR%20and%20Organisational%20Development) There are also useful links in the table to primary sources.

**Table 1:** Discovery phase activates undertaken between May 2022- December 2022

1. An evidence synthesis of *‘*grey literature’ exploring sexual harassment and misogyny in the ambulance sector:
   1. International work (Australia and Canada)
   2. Work across the blue light services – police, military, fire, and rescue.
   3. Review of ‘Freedom to Speak Up’ reports within Ambulance Trust Board Papers (Spring 2022 sample)
   4. Media reports
   5. Care Quality Commission (CQC) reports
   6. College of Paramedic activities
   7. Association of Ambulance Chief Executives (AACE) outputs
   8. Academic reporting (books, research projects, Doctorates)
   9. Regulatory body outputs (HCPC, GMC, NMC)
2. An academic narrative literature review was undertaken systematically addressing the following questions:
   1. Question 1. What is the prevalence of sexual harassment in the ambulance sector in published research?
   2. Question 2: What is the evidence for interventions to tackle sexual harassment?
3. A mapping of interventions already happening in ambulance service. Collected via Human Resource directors (HRDs, Spring 2023)
4. A review of language and terminology – appendix 1.
5. Mapping and connecting with key internal and external stakeholders – appendix 2.

# **Part B. The narrative literature review.**

This review addressed two questions:

1. What is the prevalence of sexual harassment in the ambulance sector?
2. What is the evidence base for interventions aimed at preventing or reducing sexual harassment, either within the ambulance sector or related sectors?

This summary describes the methodology used and results obtained from the review of published literature.

## **Research question 1:**

What is the prevalence of sexual harassment in the ambulance sector?

### **Research question 1: Methods**

To identify potential published research describing sexual harassment within the ambulance sector, database searched were performed. Medlin, Psych INFO, HMIC and CINAHL were searched using the following search terms:

Sexism or Misogyny or Assault or Safety or Bully\* or Harassment or Victimization or Victimisation or Threat or Aggression or Abuse or Hostility or Violence or Cyberbullying or Sex Offenses

And

Emergency response or Emergency responder or Prehospital or Pre-hospital or paramedic\* or ambulance or emergency medical technician\* or First Responder or Blue light or Emergency service\*

Additional papers were sought from searching reference lists of included. Papers were included if they referred to any form of misogyny, sexism, sexual harassment, or sexual violence, perpetrated by staff (including where this was included as a subgroup of a broader focus, such as workplace violence) and experienced by ambulance staff. Exclusion criteria included other forms of violence and workplace abuse, any forms of sexual harassment in which the perpetrators were individuals outside of the organisation (including the public, patient relatives, and professionals external to the ambulance sector) or papers in which the population was not, or did not include, ambulance staff.

### **Research question 1: Results**

In total, 26 eligible papers were included in the final analysis. The included studies were mapped to provide an overview of the current evidence, in relation to the population, the type of research or research focus, and the primary outcome. Outcomes that were not primary research outcomes, but were considered within the results, are indicated with an asterisk on the map.

In terms of the population, most studies (n=14) focused on paramedics or emergency medical technicians. Most were also studies considering the prevalence of certain workplace behaviors or events. The studies represented several different countries, including Canada, Australia, Turkey, UK, US, Pakistan, India, and Denmark.

Overall, there was little published research that had a specific focus on sexual harassment. There appeared to be many more articles focusing on external violence, with a smaller number of studies relating to internal violence, bullying or workplace culture. Sexual harassment was often included as part of broader topics, rather than being the primary research focus. However, there were references to sexual harassment in which fellow staff were perpetrators, reports of sexist attitudes within the ambulance sector and qualitative data on personal experiences of sexual harassment.

Although several studies noted that sexual harassment, sexual assault or workplace violence were more commonly experienced by female paramedics7–9, only two studies specifically explored the prevalence of sexual harassment and sexual assault within specific populations in the ambulance sector10–12. In one study by Bigham et al, 2014, which surveyed Canadian paramedics, 31.8% of female respondents and 6.3% of male respondents reported sexual harassment, with an overall prevalence of 13.7% across all paramedics surveyed10. Of all reported sexual harassment (in men, women and those that did not specify gender), 42.4% of perpetrators were reported as fellow staff10. The sexual harassment reported by paramedics included “obscene gestures, proposition, and derogatory epithets, slurs, and jokes”10. In the case of sexual assault, this was again more common in women than men (6.4% vs 1.3%) and fellow staff were reported as the perpetrator in 12.8% of all sexual assaults10. Another study by Boyle et al 2007 looked at workplace violence in Australian paramedics and found that 37.7% of female paramedics experienced sexual harassment, and 11.5% experienced sexual assault11. The differences between female and male paramedics were statistically different, with men, with a reported prevalence in male paramedics of 9.5% for sexual harassment and 1.6% for sexual assault11.

An additional analysis of this data found that of all sexual harassment incidents, in 32.7% of cases, fellow staff or other professionals were the perperators12. This was found to be the case in 46.2% of sexual assaults12. In this study, “work problems” were reported to precipitate instances of sexual harassments in 3.4% of cases12. Of concern was also the fact that in over one third of the cases of sexual harassment (34.8%), the victim did nothing; this was also the case for 16.7% of sexual assaults12. Reasons for not reporting workplace incidents of verbal or physical violence have previously been explored, and include embarrassment, the perception that no action will be taken, reporting taking too many steps and use of personal time required13. These concerns have also been reflected in staff experiences within UK ambulance trusts, with one staff member being quoted in a CQC report as saying “When sexual harassment is reported it seems to be brushed under the carpet and the person is given a second chance”2.

Reports exploring culture within UK Ambulance Trusts were also identified. These included reports of grooming, sexist behaviours, expectations of sexual favours and unwanted physical contact14,15. One staff member reported that “it was made clear to me that if I wanted to progress my career there were sexual favours that were required. Nights out, weekends away. You do as we want you to”14. Sexism and misogyny were also reported, with some individuals interviewed stating that managers and fellow staff were openly sexist towards women, believing that they were seen as less capable14, with reports of sexism also being used in the context of workload allocation and allowing “control”14.

There were also reports of student paramedics experiencing sexual harassment, sexist or sexualised behaviours16–19.

Three studies also explored scores of paramedics on scales exploring masculine ideals, sexist attitudes or attitudes towards violence against women20–22. These studies did demonstrate some elements of sexist attitudes, although it was recognised that some existing traditions and cultural values within the study population may impact on this.

## **Research question 2:**

What is the evidence base for interventions aimed at preventing or reducing sexual harassment, either within the ambulance sector or related sectors?

### **Research question 2: Methods**

A search was conducted to identify interventions focused on sexual harassment, either within the ambulance sector, or related sectors in health or emergency services. MedLine, PsychINFO, HMIC and CINAHL were searched using the following terms:

Additional papers were sought from searching reference lists of included or related papers. Papers were included if they referred to an intervention focused on any form of workplace misogyny, sexism, sexual harassment, or sexual violence, perpetrated by fellow stafff, within the ambulance sector or a related sector.

Sexism OR misogyny OR sexual harassment OR sexual safety OR sexual abuse OR sexual violence OR bully\*

Prevent OR reduce OR tackle\* OR intervention OR program\* OR address\* OR training OR culture OR recommendation\* OR guideline\* OR policy OR policies OR education OR strategy\*

Ambulance OR paramedic OR pre-hospital OR prehospital OR NHS OR national health service OR hospital OR police OR policing OR military OR fire OR emergency services OR EMT OR workplace

### **Research question 2: Results**

15 included studies were mapped to provide an overview of the current evidence, in relation to the population or setting intervention type, outcome of interest and whether the intervention had a positive or negative impact.

There were no studies specific to the ambulance sector, with the majority of studies focusing on nursing23–31. There were also few interventions specific to sexual harassment32,33. The two studies that focused on sexual harassment included an evaluation of policies in a policing context32 and manager training33. An analysis of manager training suggested that training had a positive impact on sensitivity, but not accuracy of identifying sexual harassment33. The evaluation of sexual harassment policies in policing found a non-statistically significant decrease in sexual harassment scores, and the authors noted that there were no difference in relation to how comprehensive policies were32. This suggests that training or policy alone may not be sufficient in reducing or tackling sexual harassment.

Interventions that demonstrated a positive impact relating to bullying or workplace violence included transition programmes23, workshops34,35, resilience training36, cognitive rehearsal training25,28,29,31, training35 and multimodal initiatives30. These were all in a nursing context, other than two studies which focused obstetrics and gynaecology34 and a workplace setting36. Other published literature proposed interventions in relation to bullying, workplace violence or sexual harassment included social media based interventions37, bystander training38, civility training39 and emotional intelligence training40.

## **Findings**

Five themes were identified: prevalence, prevention, leadership, training, plus policy and reporting processes.

**Finding 1: Prevalence**

Existing research on sexual harassment amongst paramedics reports a prevalence of 13.7-16.5%, for sexual assault this is estimated to be 2.8-4.3%10,11Female paramedics are more likely than their male colleagues to experience sexual harassment or sexual assault within the workplace9, with studies noting that the prevalence of sexual harassment in female paramedics is 31.58-37.7% compared with 6.3-9.5% in men; this difference is also the case for sexual assault (6.4-11.5% vs 1.3-1.6%)10,11

Broader research also reported instances of bullying and workplace violence, with one study findings suggesting that women are five times more likely than male colleagues to be assaulted by a male co-worker (OR 5.17)7Fellow staff/other professionals were reported as the perpetrator in around one third (32.7-42.36%) of all reported sexual harassment amongst paramedics. The proportion of sexual assaults in which fellow staffwere the perpetrators varied between studies, with the estimated proportion between 12.77 and 46.2%10–12Qualitative data from UK ambulance trusts reported concerns amongst existing ambulance culture, with reports of sexist culture, inappropriate sexualised behaviours, grooming and sexual harassment14,15Instances of sexual harassment were also reported by student paramedics18,19

### **Finding 2: Prevention**

Hunt et al.41, considered how different interventions could be considered as primary, secondary and tertiary levels of intervention, based on whether they are focused on prevention, response or follow up 41. The authors present arguments that prevention is the most important element, with suggestions that a zero tolerance stance, along with organisational culture to support this, is the best way to prevent sexual harassment41. This review highlights the importance of recognising antecedents of sexual harassment, and although the need for organisations to have accountability, as opposed to focusing on improving individual skills in dealing with sexual harassment behaviour41.

### **Finding 3: Leadership**

The role of those in leadership positions and the importance of having positive role models was also highlighted by several authors in relation to both bullying and sexual harassment38,40,42,47. Leadership is particularly important in relation to influencing organizational culture and setting organizational priorities. It is also important for those in leadership or influential positions to actively understand existing organizational culture and potential issues.

### **Finding 4: Training**

While there have been no published studies specifically evaluating the impact of interventions on measures relevant to sexual harassment, some specific categories of training appear to have had a positive impact on bullying. The evidence appear to mostly support cognitive rehearsal training25,28,29, in which specific situations or scenarios can be recreated to aid individuals in considering responses to the situation as well as coping mechanisms25. The cognitive rehearsal training resulted in improved knowledge and ability to identify bullying behaviours29, reduced incivility31, changes in behavior and decrease in bullying behaviours28 and, in the case of one study in which the training was delivered using a smartphone application, decreases in person‐related bullying, work‐related bullying experiences, and turnover intention25.

Although different kinds of training types and methods have either been proposed or evaluated, one important aspect is ensuring that training that is not only effective, but also meaningful to staff, rather than it appearing to be a ‘tick box’ exercise45. It may also be important to incorporate different forms of training both to consider the role of training in prevention and awareness raising, and also to support individuals who may experience sexual harassment through providing them with training on how to deal and cope with harassment41.

Recommendations on interventions aimed at addressing bullying have considered the importance of not targeting specific staff groups, but aiming to provide training across an organization, as well as using the intervention to encourage good behavior, as opposed to targeting negative behaviours46. It has also been recommended that those leading such interventions should possess relevant knowledge and have skills in both teaching and facilitating46

### **Finding 5: Policy and reporting processes**

Suggestions around what should be included within a policy on sexual harassment or bullying have been outlined42–44. These principles have informed suggested guidance on what could be incorporated into a sexual harassment policy - table 2.

**Table 2:** Suggested components of a sexual safety policy

|  |  |
| --- | --- |
| **Zero tolerance** | Policy and organisational communications should explicitly include a clear zero tolerance statement towards sexual harassment. |
| **Defining the issue** | Sexual harassment should be clearly defined within the policy, with examples to demonstrate what may constitute sexual harassment behaviours in practice. |
| **Understanding the impact** | The importance of the policy should be reiterated by outlining the impact of such behaviours. |
| **Process** | The process following reports of sexual harassment should be clearly outlined. Different channels for reporting should be made available for staff, and there should be a prompt, confidential investigation. Details of expected time frames should also be included, as well as how findings will be reported or what feedback will be provided. There should also be options for external processes when required. |
| **Confidentiality** | The policy should include a statement to clarify that principles of confidentiality will be applicable to all parties involved. |
| **Accountability** | Organisational accountability should be considered, with reports of sexual harassment triggering an evaluation, aiming to identify organisational or workplace factors that contributed to this. |
| **Co-production** | Policies should, where possible, be co-produced with staff members to ensure staff priorities and experiences are considered. |

# **Part C. Discovery phase conclusion**

The purpose of this initial phase was to gain a comprehensive picture of reported sexual harassment and misogyny in the ambulance service alongside determining the evidence-based interventions already in place.

Whilst pockets of provider, regional, and national sexual safety work across the sector was identified, this was not consistent, there was no best practice, central repository and/or sector wide steer.

During the discovery phase stakeholders (appendix 2) agreed that the methodology, adopted in the [Preventing suicide and supporting wellbeing in the ambulance sector](https://aace.org.uk/suicide-prevention-in-ambulance-services/) workstream for paramedics, would be suitable. Therefore, this workstream has three co-produced products:

a. A ‘What We Know’ document.

b. A consensus agreement signed by ambulance trusts.

c. An evidence-based set of interventions

# **References**

1. Association of Ambulance Chief Executives. Preventing Suicide and Supporting Wellbeing in the Ambulance Sector. 2022. Available from: https://aace.org.uk/suicide-prevention-in-ambulance-services/

2. Care Quality Commission. South Central Ambulance Service NHS Foundation Trust Inspection Report. 2022.

3. Berrill L. East of England Ambulance Service’s damning CQC report. Watford Observer. 2020. Available from: https://www.watfordobserver.co.uk/news/18762431.east-england-ambulance-services-damning-cqc-report/

4. Care Quality Commission. East of England Ambulance Service NHS Trust Inspection report. 2020;1–27.

5. Walker J. A theoretical study on workplace bullying and sexual harassment amongst first responders. Diss Abstr Int Sect B Sci Eng. 2019;80

6. Wilson C, Prothero LS, Williams J. Celebrating International Women’s Day: where does this leave the paramedic profession? Br Paramed J. 2022 Feb 24;6(4):1–2.

7. Touriel R, Dunne R, Swor R, Kowalenko T. A Pilot Study: Emergency Medical Services-Related Violence in the Out-of-Hospital Setting in Southeast Michigan. J Emerg Med. 2021 Apr;60(4):554–9.

8. Maguire BJ. Violence against ambulance personnel: a retrospective cohort study of national data from Safe Work Australia. Public Heal Res Pract. 2018;28(1).

9. Koritsas S, Boyle M, Coles J. Factors associated with workplace violence in paramedics. Prehosp Disaster Med. 2009;24(5):417–21.

10. Bigham BL, Jensen JL, Tavares W, Drennan IR, Saleem H, Dainty KN, et al. Paramedic self-reported exposure to violence in the emergency medical services (EMS) workplace: a mixed-methods cross-sectional survey. Prehosp Emerg Care. 2014;18(4):489–94.

11. Boyle M, Koritsas S, Coles J, Stanley J. A pilot study of workplace violence towards paramedics. Emerg Med J. 2007;24(11):760–3.

12. Boyle M, Koritsas S, Coles J. Perpetrators of violence against paramedic’s in the workplace and the paramedic’s response. In: Second International Conference on Violence in the Health Sector: “From Awareness to Sustainable Action.” 2010. p. 81–5.

13. Tay GK, Razak ARA, Foong K, Ng QX, Arulanandam S. Self-reported incidence of verbal and physical violence against emergency medical services (EMS) personnel in Singapore. Australas Emerg care. 2021;24(3):230–4.

14. Lewis D. Workplace culture at Southwestern Ambulance NHS Foundation Trust. School PUB, editor. 2018; Available from: https://southwest.unison.org.uk/content/uploads/sites/4/2018/11/Workplace-Culture-at-Southwestern-Ambulance-NHS-Foundation-Trust-1.pdf

15. Lewis D. Bullying & Harassment at South East Coast Ambulance NHS Foundation Trust. 2017.

16. Boyle M, McKenna L. Paramedic and midwifery student exposure to workplace violence during clinical placements in Australia - A pilot study. Int J Med Educ. 2016;7:393–9.

17. Boyle M, McKenna L. Paramedic student exposure to workplace violence during clinical placements - A cross-sectional study. Nurse Educ Pract. 2017;22:93–7.

18. McManamny T, Boyd L, Sheen J. Occupational risks in undergraduate student paramedic clinical placements. J Heal Saf Environ. 2013;29(1).

19. Sheen J, Boyd L, Eastwood K, Archer F, Leaf S. Student Perceptions of Adverse Health Events During Ambulance Clinical Placements. Education. 2012;2(2):6–10.

20. Çalıkoglu EO, Aras A, Hamza M, Aydin AA, Nacakgedigi O, Koga PM, et al. Sexism, attitudes, and behaviors towards violence against women in medical emergency services workers in Erzurum, Turkey. Glob Health Action. 2018 Jan;11(1):1.

21. Gumussoy S, Donmez S, Eksi A, Dal NA. Relationship of knowledge about and attitudes towards violence with recognition of violence against women among health staff in pre-hospital emergency medical services. Int Emerg Nurs. 2021;56:100975.

22. Nielsen KJ, Hansen CD, Bloksgaard L, Christensen A-D, Jensen SQ, Kyed Lotte, AI - Kyed, Morten; The impact of masculinity on safety oversights, safety priority and safety violations in two male-dominated occupations. Saf Sci. 2015;76:82–9.

23. Alshawush K, Hallett N, Bradbury-Jones C. The impact of transition programmes on workplace bullying, violence, stress and resilience for students and new graduate nurses: A scoping review. J Clin Nurs. 2022;31(17–18):2398–417.

24. Chipps EM. The influence of diagnoses, race, and medicaid enrollment on health services among the seriously mentally disabled population. Diss Abstr Int Sect B Sci Eng. 2003;64(6-B):2589.

25. Kang J, Jeong YJ. Effects of a smartphone application for cognitive rehearsal intervention on workplace bullying and turnover intention among nurses. Int J Nurs Pract. 2019;25(6):e12786.

26. Kang J, Kim JI, Yun S. Effects of a Cognitive Rehearsal Program on Interpersonal Relationships, Workplace Bullying, Symptom Experience, and Turnover Intention among Nurses: A Randomized Controlled Trial. J Korean Acad Nurs. 2017;47(5):689–99.

27. Phan S, Hampton MD. Promoting Civility in the Workplace: Addressing Bullying in New Graduate Nurses Using Simulation and Cognitive Rehearsal. J Nurses Prof Dev. 2022; Available from:

28. Stagg SJ, Sheridan DJ, Jones RA, Speroni KG. Workplace bullying: the effectiveness of a workplace program. Workplace Health Saf. 2013;61(8):333–8.

29. Stagg SJ, Sheridan D, Jones RA, Speroni KG. Evaluation of a workplace bullying cognitive rehearsal program in a hospital setting. J Contin Educ Nurs. 2011;42(9):393–5.

30. Vessey JA, Williams L. Addressing Bullying and Lateral Violence in the Workplace: A Quality Improvement Initiative. J Nurs Care Qual. 2021;36(1):20–4.

31. Razzi CC, Bianchi AL. Incivility in nursing: Implementing a quality improvement program utilizing cognitive rehearsal training. Nurs Forum. 2019;54(4):526–36.

32. de Haas S, Timmerman G, Hoing M, Zaagsma M, Vanwesenbeeck I. The impact of sexual harassment policy in the Dutch police force. Empl Responsib Rights J. 2010;22(4):311–23.

33. Buckner GE, Hindman HD, Huelsman TJ, Bergman JZ. Managing workplace sexual harassment: The role of manager training. Empl Responsib Rights J. 2014;26(4):257–78.

34. Benmore G, Henderson S, Mountfield J, Wink B. The Stopit! programme to reduce bullying and undermining behaviour in hospitals. J Heal Organ Manag. 2018 Apr;32(3):428–43.

35. Stevens S. From the field. Nursing workforce retention: challenging a bullying culture: how nurses in one Australian hospital confronted intimidation of and by nurses and took steps to remedy it. Health Aff. 2002 Sep;21(5):189–93.

36. Maidaniuc-Chirila T. A multi-mediation model of the relationship among workplace bullying, coping strategies, resilience and employees’ strain: Insights for a training programme. Psihol Resur Um Rev Asoc Psihol Indusstriala si Organ. 2015;13(1):63–82.

37. Cancio R. Addressing Military Sexual Violence by Proposing a Social Media Influencer Model. Int J Offender Ther Comp Criminol. 2021;65(8):937–54.

38. Lassiter BJ, Bostain NS, Lentz C. Best Practices for Early Bystander Intervention Training on Workplace Intimate Partner Violence and Workplace Bullying. J Interpers Violence. 2021;36(11–12):5813–37.

39. Nagy MS, Curl-Nagy DJ. Workplace civility training: An antidote to traditional sexual harassment training. Anderson Goldstein, Heppner, Heppner, Leiter, Medeiros, Nagy, Osatuke B, editor. Ind Organ Psychol Perspect Sci Pract. 2019;12(1):93–5.

40. Bennett K, Sawatzky J-A V. Building emotional intelligence: a strategy for emerging nurse leaders to reduce workplace bullying. Nurs Adm Q. 2013;37(2):144–51.

41. Hunt CM, Davidson MJ, Fielden SL, Hoel H. Reviewing sexual harassment in the workplace-An intervention model. Pers Rev. 2010;39(5):655–73.

42. Buchanan NT, Settles IH, Hall AT, O’Connor RC. A review of organizational strategies for reducing sexual harassment: Insights from the U. S. military. J Soc Issues [Internet]. 2014;70(4):687–702.

43. Colmore N, Culver R, Lee W, Kidd AD. Sexual Harassment in the Military: Implications for Civilian Nursing Policy. Online J Issues Nurs. 2019 Jan;24(1):12.

44. Duffy M. Preventing workplace mobbing and bullying with effective organizational consultation, policies, and legislation. Spec Issue Work Mobbing Bullying. 2009;61(3):242–62.

45. Varone C. Sexual harassment in the fire service: policies, training help ensure a safe & healthy work environment. Firehouse. 2009 Jul;34(7):52–4.

46. Gamble Blakey A, Smith-Han K, Anderson L, Collins E, Berryman E, Wilkinson TJ. Interventions addressing student bullying in the clinical workplace: a narrative review. BMC Med Educ. 2019;19(1):220.

47. Arnetz JE, Fitzpatrick L, Cotten SR, Jodoin C, Chang C-HD. Workplace Bullying Among Nurses: Developing a Model for Intervention. Violence Vict. 2019;34(2):346–62.

# **Appendix one. Language and terminology**

Reducing misogyny and improving sexual safety in the ambulance service

|  |  |
| --- | --- |
| **Active bystander/ upstander** | Someone who chooses to challenge unacceptable or threatening behaviour |
| **Intersectionality** | Coined by Professor Kimberlee Crenshaw to describe how race class gender and other individual characteristics intersect with one another and overlap, and the compound effect of that intersection. |
| **Misandry** | Dislike of, contempt for, or ingrained prejudice against men |
| **Misogyny** | Dislike of, contempt for, or ingrained prejudice against women. |
| **Misogynoir** | Hatred directed towards Black women where race and gender both play roles in bias the term was coined by Black feminist Moir Bailey in 2010. |
| **Non recent experiences** | Non-recent sexual harassment, sometimes called historical sexual harassment. |
| **Passive bystander** | A passive bystander is someone who witnesses a biased behaviour but does nothing about it. |
| **People who have been affected by sexual incidents** | A person who has been directly involved in or witnessed sexualised behaviour or activity that was carried out by another individual. The use of “affected” includes the potential to be affected both physically and psychologically at the time of the incident and in the future. |
| **Psychological safety** | A shared belief that the team is safe for interpersonal risk-taking. Establishing a climate of psychological safety allows space for people to speak up and share their ideas. |
| [**Sexual assault**](https://www.nhs.uk/live-well/sexual-health/help-after-rape-and-sexual-assault/) | Sexual assault is an act that a person did not consent to or is forced into against their will. It is a form of sexual violence and includes rape (an assault involving penetration of the vagina, anus or mouth by a penis), or other sexual offences such as groping, forced kisses, child sexual abuse, or the torture of a person in a sexual manner. |
| [**Sexual harassment**](https://www.equalityhumanrights.com/sites/default/files/sexual-harassment-and-the-law-guidance-for-employers.pdf) | Sexual harassment occurs when a person engages in unwanted conduct of a sexual nature that has the purpose or effect of violating someone’s dignity or creating an intimidating, hostile, degrading, humiliating or offensive environment for them.  Example of sexual harassment are:  \*Sexual comments or jokes  \*Displaying sexually graphic pictures, posters, or photos  \*Suggestive looks, staring or leering  \*Intrusive questions about a person’s private sex life, and discussing your own sex life |
| [**Sexual misconduct**](https://www.parliament.uk/mps-lords-and-offices/standards-and-financial-interests/house-of-lords-commissioner-for-standards-/code-of-conduct-for-the-house-of-lords/code-of-conduct-appendices/) | Sexual misconduct describes a range of behaviours including sexual assault, sexual harassment, stalking, voyeurism, and any other conduct of a sexual nature that is non-consensual or has the purpose or effect of threatening, intimidating, undermining, humiliating, or coercing a person. |
|  |  |
| **Sexual safety** | Sexual safety refers to being and feeling psychologically and physically safe, including being free of, and feeling safe from, behaviour of a sexual nature that is unwanted, or makes another person feel uncomfortable, afraid, or unsafe. |
| [**Sexual violence**](https://iris.who.int/bitstream/handle/10665/77434/WHO_RHR_12.37_eng.pdf) | Sexual violence encompasses acts that range from verbal harassment to forced penetration, and an array of types of coercion, from social pressure and intimidation to physical force. |
| **Victimisation** | Victimisation is whereby someone treats an individual badly or subjects an individual to a detriment because they complain about discrimination or help someone who has been the victim of discrimination. Victimisation is unlawful under the Equality Act 2010. |

# **Appendix two. Project stakeholders**

|  |  |
| --- | --- |
| NHS England   * Office of the Chief Allied Health Professions Officer (CHAPO) * Workforce Training and Education Directorate (WTE) * Urgent, Emergency Care (UEC) team * Intensive Support team * Communications * Domestic Abuse and Sexual Violence (DASV) team   Office of Health Inequalities and Disparities (OHID)  College of Paramedics (including the student committee)  The Ambulance Staff Charity (TASC)  Social Partnership Forum  NHS Employers  Chief AHP Advisors   * Scotland * Northern Ireland * Wales | Association of the Ambulance Chief Executives (AACE)   * Council * Ambulance Trust HR Directors (HRDs) * National Directors of Operations Group (NDOG) * Women’s Network * National Ambulance Diversity and Inclusion Forum (NADIF)   Ambulance Trusts   * England including the Isle of Wight * Wales * Scotland * Northern Ireland * Wellbeing guardians * “Freedom to Speak Up” Guardian network.   National Guardians Office  Researchers working in related field.  Individuals with lived experience in the Ambulance service |

Reducing Misogyny and Improving Sexual Safety in the Ambulance Service

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