

mental health and paramedics

Submission

For

**Senate Inquiry into the high rates of
mental health conditions experienced by
first responders, emergency service workers
and volunteers**

June 2018

"At the root of this dilemma is the way we view mental health in this country. When it comes to mental health conditions, we often treat them differently from other diseases like cancer, diabetes or asthma. And that makes no sense. Whether an illness affects your heart, your leg or your brain, it's still an illness, and there should be no distinction."

Michelle Obama

Former First Lady of the USA

'Change Direction' Mental Health Summit, Newseum, Washington, 4 March 2015¹

¹ Office of the First Lady, The White House, *Remarks by The First lady at "Change Direction" Mental Health Event*, Washington D.C., 4 March 2015 <https://bit.ly/2pJBdTg> accessed 01/06/2018

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EXECUTIVE SUMMARY

Paramedics are likely to suffer physical and psychological harm as a work-related injury. They are not alone, and other personnel employed by paramedic (aka ambulance) service providers and emergency services may also suffer mental distress. This harm may come from witnessing and participating in traumatic events and through the accumulation of internal and external work-related stressors including assault and violence - often fuelled by alcohol or drugs of addiction.

This paper is a formal submission to the Senate Inquiry into the high rates of mental health conditions experienced by first responders, emergency service workers and volunteers.

It embodies the input from hundreds of paramedics and other personnel at all levels over a period of more than ten years, embracing women and men with a diversity of professional and academic backgrounds and with varying periods of service, exposure to critical incidents, and from both current and retired cohorts. They have emphatically pointed to the need to enhance the culture of paramedic services as a key step in reducing paramedic mental distress.

This submission explores the need for policies and organisational arrangements that will enhance the mental health and well-being of public safety personnel with specific reference to the identified risks associated with paramedic (aka ambulance) services.

The recommendations cover a range of initiatives including the:

- establishment of a National Health Care Commission;
- adoption of a 'health in all policies' strategy to drive national policy initiatives;
- establishment of a national collaborative research and policy unit for first responders;
- the introduction of legislation to cater better for mental health illness and compensation;
- establishment of an Australian national Paramedic Services Standard;
- independent accreditation and licensing of all paramedic service providers;
- oversight of all paramedic services through an appropriate care and quality monitor;
- inclusion of paramedic representatives in health policy and safety frameworks;
- inclusion of mental health and addiction content as part of accredited paramedic education;
- enhanced internal service communications and management accountability including measures designed to overcome bullying, harassment and discrimination;
- proposals for early identification, rapid and sensitive response and effective support designed to enhance the mental health and well-being of paramedics and other personnel; and,
- mandatory tracking and reporting of mental injury as an occupational health requirement.

While the submission outlines the importance of significant behavioural support in paramedic service organisations, the proposals also have wider application to other public safety agencies such as police and emergency services.

The objective is to ensure the long-term mental health of paramedics and other first responder groups (and associated personnel) in the public safety and health and care domains.

BACKGROUND

1. On 27 March 2018, the Australian Senate referred an inquiry into the role of Commonwealth, state and territory Governments in addressing the high rates of mental health conditions experienced by first responders, emergency service workers and volunteers² to the Education and Employment References Committee. The Inquiry terms of reference are outlined in *Appendix A*.
2. This submission is made in a personal capacity. It places a primary focus on paramedics and the delivery of paramedic services, albeit reference is also made to other public safety personnel (PSP) which includes police, firefighters, and emergency service responders.
3. The author has worked in a professional capacity for more than 25 years with government law enforcement agencies, health departments and professional associations including the Australian and New Zealand College of Paramedicine (ANZCP)³ and Paramedics Australasia (PA).⁴
4. He currently holds a personal appointment as Adjunct Associate Professor within the School of Health, Medical and Applied Sciences of the Central Queensland University and is an Honorary Fellow of PA awarded in 2010 for services to paramedicine.
5. A National Executive member of the Australian Health Care Reform Alliance (AHCRA)⁵ he is a member of the Health Advisory Committee of the international Talisman Healthcare Group.⁶
6. As the Principal Policy Advisor to PA From 2007 to 2015, he was responsible for the development of proposals for the national registration of paramedics in Australia and New Zealand. This will see paramedics become the 15th registered health profession in late 2018 under the National Registration and Accreditation Scheme. He is a member of the National Paramedic Registration Stakeholder Reference Group for the implementation of registration.
7. With a professional career spanning more than 50 years, the author has extensive experience in conducting high-level system reviews and forensic investigations in Australia and overseas. Over the past ten years his work has included the preparation of a number of submissions for inquiries into paramedic (aka ambulance) service management and operations.
8. These inquiries often revealed unacceptable levels of mental health distress or occupational stress injuries (OSI) affecting paramedics, their colleagues and families.
9. Significantly, the author's submissions have been informed by operational analysis and wide-ranging interviews with hundreds of practicing and retired paramedics (and other personnel including other health professionals, educationalists, students and patients) employed by or associated with paramedic services across Australia.
10. The findings and recommendations of this submission are informed by their stories.

² Australian Senate, Hansard Debates (p 2264), 27/03/2018 <https://bit.ly/2JwvEEP> accessed 14/06/2018

³ Australian and New Zealand College of Paramedicine, <https://www.anzcp.org.au/>, accessed 14/06/2018

⁴ Paramedics Australasia, <http://www.paramedics.org.au/> accessed 14/06/2018

⁵ Australian Health Care Reform Alliance, <http://www.healthreform.org.au/> accessed 14/06/2018

⁶ Talisium, Our people, <https://talisium.com/the-people/> accessed 14/06/2018

THE WORK OF PARAMEDICS

11. Paramedics are best known for their role working with the major public-funded ambulance services, where they provide vital out-of-hospital and front-line care in responding to urgent and unscheduled health needs. A brief outline of Australia's major public paramedic service models is at *Appendix B*. Well over 100 other private paramedic and aeromedical services operate.
12. Paramedic practice may involve a range of higher risk clinical interventions as well as making in-depth assessments of a patient and providing recommendations on the most appropriate treatment pathway(s).
13. Paramedics are renowned for the level of public trust they hold within the community. Patients readily trust paramedics with their personal information, medical history, current medications (as feasible) and rely on them to provide the best possible care at their time of critical need.
14. Paramedic services in Australia have been transforming as they embrace technological and clinical changes and transition into more complex service providers. Across the spectrum of care, their career and volunteer personnel deliver emergency out-of-hospital care and transport, community-based care, medical retrieval and health transport services to a population ranging from dense metropolitan to rural and very remote settings.
15. Public emergency medical services are generally activated by a telephone call to a triple zero number where the incident is assessed and prioritised in regional call centres. In more densely populated areas the service providers respond with the dispatch of one or more qualified paramedics in an ambulance or another mode of transportation (car, bike, helicopter) depending on the situation.
16. Activation of crisis responses in less populated regions may involve mobilising first-aid volunteers with basic first responder training. In other circumstances, the Royal Flying Doctor Service also may respond. In more isolated settings such as on a ship, construction site, mine site or gas field, paramedics may work alone or provide the lead for an emergency response team.
17. First responders may be called at any time to life-threatening situations or major trauma and disaster incidents which involves working in a stressful and time-critical environment. Paramedics and other public safety personnel (PSP) thus may work at any hour of the day or night, under inclement weather conditions, and in situations of high physical risk exposure.
18. The functional roles of paramedics may vary from emergency trauma response; responding to drug overdose emergencies; performing community health checks; responding to medical emergencies associated with diseases such as asthma or diabetes; to providing initial care to those suffering a mental health crisis.

"We do a lot of chronic health conditions; we do a lot of work with seniors ... we go to a lot of palliative patients — all incredibly rewarding calls where you feel like you're really making a difference in these people's lives."

Anonymous – Advanced Care Paramedic

19. Paramedics may provide medical care to unconscious, injured persons while surrounded by disorientated, inebriated, substance affected and combative people. On occasion, paramedics are subjected to inappropriate and abusive language or physical assaults, which form a significant external stressor both in real life and in anticipation.

20. Studies have shown that paramedics suffer greater than normal occupational injuries, often associated with the movement (e.g. carrying and lifting) or extrication of patients.^{7,8} They also suffer disturbingly high levels of Acute Stress Disorder (ASD) and Post Traumatic Stress Disorder (PTSD)⁹ and other forms of mental distress.

21. Paramedics may miss meals and tend to work longer hours than the rest of the employed population with 36 per cent of paramedics working full time working longer than 49 hours per week compared to 26 per cent of the wider population (2011 Census analysis).

22. The *Annual Report on Government Services (RoGS)*¹⁰ prepared by the Productivity Commission provides comprehensive information on government-funded ambulance services in Australia but excludes military medics and does not include consistent or comprehensive data on private sector services. RoGS is focussed on service metrics with limited coverage of patient health outcomes or outcome metrics associated with practitioners such as physical or mental injuries. Patient outcomes for certain events such as out-of-hospital cardiac arrest are available from voluntary collaborative groups including the Australian Resuscitation Outcomes Consortium (Aus-ROC) Epistry.

23. One should not forget the significant role played by private sector services in maintaining the health and well-being of the community. These services employ paramedics working in aeromedical services, entertainment and event settings, patient transport, on remote area gas fields or mines, on ships, and in humanitarian and peace-keeping activities across the region.

24. Paramedics working in these industrial and occupational health roles may be required to undertake a substantial volume of other work apart from the traditional emergency response, such as health assessments, rehabilitation, staff exercise programs, and work health and safety roles.

25. In this submission, the author refers to paramedics in the context of a distinct cohort of professional practitioners who may or may not work for a paramedic service and may practice as an individual or employee of any health service provider.

26. The author has not conducted a specific investigation of the incidence of mental distress and suicidality within the paramedic and first responder cohorts across Australia. However, his close engagement with the profession over the past ten years has provided deep exposure to the prevailing culture of services and the state of practitioner well-being.

27. The paramedics of Australia also operate similarly to paramedics in other comparable jurisdictions such as New Zealand,¹¹ Canada, and the United Kingdom (UK) and much of the experience and research in those jurisdictions can be applied (generally) to Australia. Taken together, the author holds an ample evidence base from which to draw informed views.

⁷ Maguire BJ, Hunting K, Guidotti T, Smith G, *The epidemiology of occupational injuries and illnesses among emergency medical services personnel*, January 2004, bit.ly/1Nqtn3v accessed 12/06/2018

⁸ Maguire BJ, O'Meara P, Brightwell R, O'Neill B, Fitzgerald G, *Occupational injury risk among Australian paramedics: an analysis of national data*, *Med J Aust* 2014; 200 (8): 477-480. || doi: 10.5694/mja13.10941 Online: 5 May 2014, bit.ly/1OdhJfa accessed 12/06/2018

⁹ Julia Medew, *Health minister Jill Hennessy describes rates of PTSD among paramedics as disturbing*, *The Age*, 15 May 2015, bit.ly/1EIWc8f accessed 12/06/2018

¹⁰ Report on Government Services – Part E Chapter 11, *Ambulance services 2018*, Productivity Commission Australia, <https://bit.ly/2MtSF9x> accessed 11/06/2018

¹¹ Hugo Goodson, *A New Zealand Perspective on Organizational Culture in EMS*, *Journal of Emergency Medical Services (JEMS)*, October 1, 2016. <https://bit.ly/2HvXXxj> accessed 22/05/2018

THE EXTENT AND PROBABLE CAUSES OF PARAMEDIC DISTRESS

28. Paramedics are among the health practitioners who have been found to suffer greater than normal psychological harm as a work-related injury. This may manifest itself in different ways including various stages of mental distress and post-traumatic stress injury (PTSI - aka post-traumatic stress disorder or PTSD) and even progress to suicide. For simplicity, the author will tend to use the term occupational stress injury (OSI).

29. The quality of paramedic care revolves around the expertise and fitness-to-practice of the individual practitioner in conjunction with the employment setting and operational environment. A practitioner who is both physically and mentally healthy will provide better patient care, to the overall benefit of the community as well as to the benefit of the individual and their colleagues.

30. The conduct of the present Senate Inquiry¹² is self-evidently a measure of the concern in Australia arising from the high incidence of suicide and self-harm by current or former personnel of paramedic services and other PSP within the emergency workforce sector.

31. Independent Coronial data^{13,14} indicate that one police officer, paramedic or firefighter in Australia is taking their own life every six weeks, and experts have warned that emergency workers are not getting the support and treatment they need to cope with OSI.

32. While chilling in its implications, that Coronial data is unlikely to show the full extent of harm being suffered by frontline personnel in the public safety sector and which may go unreported or is not attributed to the workplace because of separation in time, location and employment status.

33. The indications are that those in need of care are not being identified early enough. In addition, there are significant cultural obstacles that deter them from seeking the care they require, including misplaced concerns that professional identity requires the withholding of personal emotions. Despite the resources available, the coordination of support and collaboration among stakeholders must be improved across the emergency and healthcare sectors to protect better the long-term health of PSP, their families and associates who often suffer vicarious harm.¹⁵

“It is an odd paradox that a society, which can now speak openly and unabashedly about topics that were once unspeakable, still remains largely silent when it comes to mental illness”

Glenn Close

American Actress and Mental Health Activist

34. To improve the current situation of deplorable human cost, we must change the culture of services so that mental health is seen as an important element of the human condition — something that we all have and should pay attention to. Nationally, paramedic services and

¹² Australian Senate, *The role of Commonwealth, state and territory Governments in addressing the high rates of mental health conditions experienced by first responders, emergency service workers and volunteers*, Education and Employment References Committee. <https://bit.ly/2HbaUS3> accessed 04/05/2018

¹³ National Coronial Information System (NCIS), *Intentional Self-Harm Fact Sheet: Emergency Services Personnel*, <https://bit.ly/2svMSYG> accessed 01/06/2018

¹⁴ Knowles Lorna, ABC National News, *New figures reveal high suicide rates amongst emergency workers; experts warn PTSD sufferers not getting needed treatment*, <http://ab.co/1dO3q4D> accessed 01/06/2018

¹⁵ The Paramedic Observer, *After the towers fell*, Facebook, 16 September 2017, <https://bit.ly/2x18H2v> accessed 21/06/2018

practitioners must acknowledge the reality of mental health impairment and discard the stigma and reluctance to seek care because of embarrassment, shame, or guilt.

35. The 2016 Independent Oversight Panel Review (IOP) of St John Ambulance Service¹⁶ in Western Australia (WA) is particularly helpful through its identification of a significant body of literature highlighting the higher risks and psychological disorders associated with PSP. The body of evidence from the IOP is submitted in its entirety as being relevant to the current Inquiry and in particular Section 2 pp 31-50.

36. The author agrees with the findings of the IOP - which aligns with his assessment of the lived experiences outlined by members of the profession and the findings of published research in jurisdictions that share common goals, similar accredited educational pathways and performance data.¹⁷

“The particular occupational hazards arising from traumatic incidents that ambulance officers attend, means this workforce carries a foreseeable risk of psychological injury. The body of literature points to the probability of developing posttraumatic stress disorder and the risk arises from the cumulative exposure across the course of a career.”

Review of St John Ambulance Health and Wellbeing/Workplace Culture (2016)

37. Past studies of mental illness and suicide related to health professionals in Australia and New Zealand such as the *Suicide by health professionals* study¹⁸ by Milner et al. have generally dealt with the registered health professions. The Milner study showed the clear need for targeted prevention of suicide by health professionals. It also showed that the rate of suicide for health professionals with access to prescription medicines was higher than for health professionals without ready access.

38. Paramedics have access to addictive drugs such as fentanyl, morphine and ketamine, and are exposed to risk of diversion to support addiction - an acknowledged risk among those with access to these drugs, including doctors and nurses. They operate in uncontrolled environments that are subject to an increasing level of physical abuse and assault^{19,20} which now places paramedic practice among the higher-risk occupations and has resulted in strong calls²¹ for preventive actions.

¹⁶ Independent Oversight Panel (2016). *Review of St John Ambulance Health and Wellbeing/Workplace Culture*. August 2016 <https://bit.ly/2MuO5Ym> accessed 12/06/2018

¹⁷ Ben Beck et al, *Regional variation in the characteristics, incidence and outcomes of out-of-hospital cardiac arrest in Australia and New Zealand: Results from the Aus-ROC Epistry*, European Resuscitation Council, May 2018 Vol 126 [46-57] DOI: <https://doi.org/10.1016/j.resuscitation.2018.02.029> accessed 04/06/2018

¹⁸ Allison J Milner, Humaira Maheen, Marie M Bismark and Matthew J Spittal, *Suicide by health professionals: a retrospective mortality study in Australia, 2001–2012*, Med J Aust 2016; 205 (6): 260-265. doi: 10.5694/mja15.01044 19 September 2016, <https://bit.ly/2clQXzZ> accessed 03/06/2018

¹⁹ NZ Herald, *St John highlight dangers paramedics face on the job*, NZ Herald, 15 December 2016, <https://bit.ly/2y0xtoc> accessed 07/06/2018

²⁰ Maguire BJ, *Violence against ambulance personnel: a retrospective cohort study of national data from Safe Work Australia*, Australia. Public Health Res Pract. 2018;28(1):e28011805. 15 March 2018 <https://doi.org/10.17061/phrp28011805> accessed 12/04/2018

²¹ Leah Flynn, *Assaults against St John ambulance workers rising*, Stuff National, 4 October 2016, <https://bit.ly/2y9tFkT> accessed 07/06/2018

39. The advent of paramedic registration should help to bring about the inclusion of paramedics in future comparative research which would provide more definitive data. However, specific and targeted action is needed now, if we are to protect the paramedic workforce.

40. Of direct relevance in assessing the prevalence of mental distress is the study of *Mental Disorder Symptoms among Public Safety Personnel in Canada*²² which explored the mental disorder symptom frequencies and severities for Canadian PSP. The study surveyed 5813 correctional workers, dispatchers, firefighters, paramedics, and police officers who are exposed to potentially traumatic events during their work.

“Our public safety personnel have unique workplace environments, where trauma exposure is the rule rather than the exception. That exposure is different for public safety personnel than for military personnel, not better, not worse, but different.

Our public safety personnel are deployed at home in an environment of ongoing uncertainty, often for decades. They have complex roles, such as providing protection, law enforcement, and community development. Accordingly, they require dedicated and specialized resources to ensure their mental health.”

Dr Nicholas Carleton²³

Department of Psychology, University of Regina

41. The Canadian study showed that many PSP (44.5%) screened positive for clinically significant symptom clusters consistent with one or more mental disorders. This level is some four times higher²⁴ than the diagnostic rates for the general population²⁵ (10.1%). It is also disturbingly higher than earlier studies²⁶ which suggested the rate of anxiety among paramedics to be as high as 22%, with depression 10% and suicidal ideation 10%.

42. The use of current symptoms also precluded lifetime assessments, thus obscuring important information which might see late development and even higher prevalence of distress.

43. These figures, along with other studies, show paramedics are an outlier group in terms of prevalence. The higher rates for recent studies and significant differences across occupational categories and locations also underscore the need for more research to identify the diverse risk and resiliency factors that may inform changes likely to improve mental health.

²² R. Nicholas Carleton et al, *Mental Disorder Symptoms among Public Safety Personnel in Canada*, The Canadian Journal of Psychiatry 2018, Vol. 63(1) 54-64 <http://journals.sagepub.com/doi/pdf/10.1177/0706743717723825> accessed 03/06/2018

²³ Parliament of Canada, SECU, *Evidence - Standing Committee on Public Safety and National Security, 1st Session, 42nd Parliament, 22 March 2016* (Nicholas Carleton, Associate Professor, Department of Psychology, University of Regina, as an individual). <https://bit.ly/2LYETvf> accessed 04/06/2018

²⁴ Alison Crawford, *Researchers find significantly higher rate of mental disorders among first responders*, CBC News 30 August 2017 <https://bit.ly/2vKLv75> accessed 04/06/2018

²⁵ Statistics Canada. *Rates of selected mental or substance use disorders, lifetime and 12 month, Canada, household population 15 and older, 2012*. Canadian Community Health Survey—Mental Health, 2012. Ottawa (Canada): Government of Canada; 2012

²⁶ P Bennett, Y Williams, N Page, K Hood, and M Woollard, *Levels of mental health problems among UK emergency ambulance workers*, Emerg Med J. 2004 Mar; 21(2): 235–236. doi: 10.1136/emj.2003.005645 accessed 05/06/2018

44. Despite some caveats, the Canadian study lends strong support for a strategic action plan supported by rigorous and robust research, including a full epidemiology study, to support mental health – a theme that was raised in the Australian context by the WA review of St John Ambulance.

“As a consequence, it is important that a strategy exists for identifying and managing those at risk in emergency settings such as the Western Australian ambulance service.”²⁷

Strategies and specific guidelines for Australia, endorsed by the NHMRC, have also been published for the diagnosis and treatment of trauma-related disorders that should inform the provision of prevention and treatment services in the emergency services.”²⁸

Review of St John Ambulance Health and Wellbeing/Workplace Culture (2016)

45. In 2016, the Prime Minister of Canada mandated the development of a National Action Plan to address PTSI/PTSD among PSP.²⁹ In 2018 the Paramedic Association of Canada in partnership with the Paramedic Chiefs of Canada, the Canadian Standards Association and the Mental Health Commission of Canada have launched a new Standard³⁰ (*CSA Z1003.1 Psychological Health and Safety in the Paramedic Service Organization*), which offers sector-specific guidance for developing and maintaining a psychologically healthy and safe workplace.

46. The CSA Standard specifically helps paramedic workers and employers to:

- Raise awareness of associated stigma, self-stigma and harassment;
- Systematically identify sources of stress and psychological hazards; and
- Examine measures that can be implemented to address those hazards.

47. The CSA Standard provides additional guidance and compliance requirements that complement other guidelines such as the US Vicarious Trauma Toolkit.³¹

48. In recognition of the impact of employment factors, mental health problems experienced by PSP in Canada as an outcome of active duty increasingly have been labelled as OSI - consistent with the recognition of PTSI/PTSD as a work-related injury.

49. Another study by Petrie et al. undertook a systematic review of 27 international studies reporting on 30,878 ambulance personnel resulting in 18 studies for meta-analysis.³² The results demonstrated estimated prevalence rates of 11% for PTSI/PTSD, 15% for depression, 15% for anxiety, and 27% for general psychological distress amongst ambulance personnel, with the date of data collection a significant influence on observed heterogeneity.

²⁷ McFarlane, AC, & Bryant, RA. (2007). *Post-traumatic stress disorder in occupational settings: anticipating and managing the risk*. *Occup Med (Lond)*, 57(6), 404-410.

²⁸ The Australian Centre for Posttraumatic Mental Health. (2007). *Australian Guidelines for the Treatment of Adults with Acute Stress Disorder and Posttraumatic Stress Disorder*. Melbourne, Victoria: ACPMH

²⁹ Oliphant RC. *Healthy minds, safe communities: supporting our public safety officers through a national strategy for operational stress injuries*. Standing Committee on Public Safety and National Security, editor. Ottawa (Canada): Standing Committee on Public Safety and National Security, 2016. <https://bit.ly/2H2UaaV> accessed 04/06/2018

³⁰ CSA Group, *New CSA Standard Addresses Psychological Health and Safety for the Paramedic Community - A Canadian First*, Toronto April 226, 2018. <https://bit.ly/2r4sHzs> accessed 04/06/2018

³¹ The Paramedic Observer, *Vicarious Trauma Toolkit*, Facebook 27/04/2018 <https://bit.ly/2JygCh8> accessed 04/06/2018

³² Petrie et al, *Prevalence of PTSD and common mental disorders amongst ambulance personnel: a systematic review and meta-analysis*, *Soc Psychiatry Psychiatr Epidemiol*. 2018 Jun 5. doi: 10.1007/s00127-018-1539-5. <https://bit.ly/2JBtJOF> accessed 07/06/2018

50. There is no doubt that regular exposure to potentially traumatic events, including threatened or actual physical assaults, are associated with increased risk for the development of mental injuries, including post-traumatic stress injury or disorder (PTSI/PTSD), major depressive disorder (MDD), panic disorder (PD), generalised anxiety disorder (GAD), and social anxiety disorder (SAD), as well as vulnerability for an alcohol use disorder (AUD).

51. This outcome is consistent with several studies into Australian ambulance services and their management and operations. Recent examples are the NSW Ambulance Service³³, the ACT Ambulance Service³⁴, St John Ambulance (WA), St John Ambulance NT³⁵ and the work of a special Committee established by the Victorian government to review the Victorian Ambulance Service. Victoria has since taken a world-leading proactive approach³⁶ in developing appropriate responses to change its organisational culture and enhance staff well-being.

“This is why the mental health of our staff must be top of the agenda for all ambulance and EMS agencies. We can never accept that psychological injury is just part of the job.”

*Adjunct Associate Professor Tony Walker ASM
Chief Executive Officer, Ambulance Victoria*

THE CENTRAL IMPORTANCE OF ORGANISATIONAL CULTURE

52. Governance underpins corporate culture and plays a key role in determining the interpersonal outcomes which are then reflected in operational performance. The public interest is best served if paramedic services are imbued with good morale and that service personnel share a common goal of best practice health care delivery openly and transparently.

53. That view of transparency aligns with the principle commonly known as the Duty of Candour.³⁷ While most often applied to patient relationships, the principle also means that healthcare professionals must be open and honest with their colleagues, employers and relevant organisations; and take part in reviews and investigations as needed.

54. The principle requires healthcare professionals to raise concerns where appropriate and to support and encourage each other in frank and open discussion. These practices are conducive to good morale and participative management in any setting or jurisdiction.

55. In numerous interviews, persistent common threads among the nominated internal stressors have been allegations of poor communication, bullying, harassment, intimidation, discrimination, breach of confidentiality, favouritism, conflict of interest, and nepotism as a part of organisational

³³ New South Wales Parliament. Legislative Council. General Purpose Standing Committee No. 2, *The management and operations of the NSW Ambulance Service*: [report], Sydney, NSW, October 2008. ISBN 978192128285 <http://bit.ly/1IEv8MZ> accessed 08/06/2018

³⁴ Kristopher Knaus, *'Toxic management culture': Opposition to push for release of full ambulance culture review*, The Canberra Times 18 March 2015, <http://t.co/eO8ydEpCuB> accessed 12/07/2015

³⁵ Neale Fong, *NT Road Ambulance Service Scoping Review*, Department of Health, Northern Territory Government, 1 December 2017 <https://bit.ly/2A66cxk> accessed 12/06/2018

³⁶ The Paramedic Observer, *Tackling bullying and harassment in health*, Facebook 27 April 2017, <https://bit.ly/1NQNWBC> accessed 02/06/2018

³⁷ Care Quality Commission, *New NHS regulations to improve openness and transparency*, <http://bit.ly/1tvxv8l> accessed 04/06/2018

culture. A recent survey completed by members of the Australian Paramedics Association in NSW indicated that 73% of survey participants had experienced bullying, harassment or discrimination while working for NSW Ambulance.

56. The 2017 independent scoping review^{38,39} of road ambulance services in the Northern Territory (NT) also acknowledged problems with bullying and harassment and noted the views from paramedics that complaints weren't dealt with properly by management. This reflects similar observations about the St John Ambulance (WA) service in the 2016 IOP report.

57. Among the key concerns raised by paramedics are that support from senior colleagues is often lacking, and paramedics were themselves responsible for initiating any calls for assistance regarding exposure to critical incidents or the display of any symptoms of psychological distress. An unwillingness to recognise and understand the signs of distress has been noted by employees across all jurisdictions as being part of the culture of paramedic services.

58. At the same time, these comments are accompanied by fiercely loyal and glowing comments about the objectives of the organisation and the altruism and commitment of staff. Management and practitioners alike focus on protecting the image of paramedic services as an element in maintaining both personal esteem and public confidence.

"You get to work alongside some of the most hard working, committed and selfless people - lots of training and personal development opportunities due to the in-house training resources."

Anonymous

59. High organisational morale is generally viewed as a:

- strong sense of enthusiasm and commitment to a common unifying goal;
- state of individual psychological well-being based upon a sense of confidence, usefulness and purpose; and
- high degree of mental or moral confidence of a person or group; a spirit of optimism.

The author has outlined some implications of organisational morale in *Appendix C*.

60. In the past, many paramedic services were less conscious of workplace morale. The altruistic nature of the paramedic and volunteer workforce was such that morale often was not treated as a fundamental workplace and management issue requiring proactive support. That attitude is changing as research studies have shown that there is a direct correlation between positive morale and overall personnel well-being and productivity (in this case – patient care).

61. Another indicator of the need for cultural change, and which is particularly evident in the United States, is the diminishing pool of volunteers prepared to tolerate the stresses and other

³⁸ Hayley Sorensen, *NT ambos to stay with St John despite 'major problems', new review finds*, NT News, 9 December 2017, <https://bit.ly/2HWZsop> accessed 12/06/2018

³⁹ Fong N, *NT Road Ambulance Service Scoping Review*, Department of Health, Northern Territory Government, 1 December 2017. <https://bit.ly/2A66cxk> accessed 12/06/2018

demands posed by out of hospital and emergency services unless there are compensating factors⁴⁰ that enthuse the participants.

62. A reluctance to volunteer has particular implications for paramedic services in less populous regions in Australia despite rural areas being noted for their community spirit.

63. There are close parallels between paramedic practice and edgework - which involves the exercise of skilful practices combined with emotional intensity. Emotions such as fear, excitement and anxiety are central to edgework, but so is their control. Mental toughness, the ability to master and control the fear that one is experiencing and keep calm, is an integral aspect of edgework.

64. A recent study of NHS ambulance services in England used the concept of edgework⁴¹ in exploring how emergency workers responded to multidimensional work intensity across four distinct but interrelated dimensions: temporal; physical; emotional; and organisational. The study of work culture unearthed an intriguing mixture of edgy and intense elements intermingled with mundane, operational, bureaucratic work life.

65. Many frontline responders complained bitterly about working in the ambulance service yet also frequently described life on the road serving the public as 'the best job in the world'.

66. That view of fulfilling work must be tempered by numerous formal inquiries that have highlighted the 'toxic' workplace environment within paramedic services⁴² through the presence of cultural shortcomings, with top-down and command style management practices common.

"There are some extremely old school ideas about work and productivity, which just doesn't make it competitive in this day and age. Staff turnover is very high in some areas and just accepted without exploring if it's good or bad."

Anonymous

67. There is no doubt that professional paramedic employment involves conflict between elements of work that are rewarding and those that are unpleasant, tiresome, unwanted or dangerous. Certain elements of emergency work are intrinsically intense (temporally, physically, and emotionally) and these elements are part of what imbues paramedicine and emergency occupations with meaning.

68. The edgework study found that organisational pressures were typically described as the most challenging and the least worthwhile form of intensity, posing a considerable challenge to the sustainability of employment in these fields. High work intensity is expected, and to some extent actively sought, because nothing can be more worthwhile than saving lives and assisting the public.

69. The study highlights the importance of organisational culture and morale in achieving a physically and mentally healthy workforce. The core meaning of the work will always contain elements of risk, romance and excitement, but the routine pressures placed on paramedic services, resource shortages, and massive demand are making 'real ambulance work' harder to realise.

⁴⁰ Edward Granter, Paresh Wankhade, Leo McCann, John Hassard, Paula Hyde, *Multiple Dimensions of Work Intensity: Ambulance Work as Edgework*, British Sociological Association, Work Employment and Society, 19 March 2018, <https://doi.org/10.1177/0950017018759207> <https://bit.ly/2rzS3Fz> accessed 06/06/2018

⁴¹ Ibid

⁴² The Paramedic Observer, *Regrettably, Ambulance Services appear to be too often prone to these cultural shortcomings*, 6 July 2015. <https://tinyurl.com/y8xh3rk8> accessed 06/06/2018

“What is meant by institutional health: workplace conditions, relational toxicity, administrative intrusions, time pressures, excessive workload, resource limitations, poor job satisfaction, poor job engagement, nepotism, bullying, harassment, sexism, poor rosters, etc.”

Anonymous

70. These negative aspects of paramedic work are being exacerbated by the growing prevalence of abuse and assault in the field which has added to the distress of paramedics and has resulted in widespread calls for ‘zero tolerance’ of assault on PSP from services, practitioners and politicians.

71. The behavioural impacts on personnel are not uniform, with the experiences in different jurisdictions, different services and even across different regions showing significant variability. However, job satisfaction, employee health and well-being and overall attitudes within the workplace hold great significance in terms of minimising mental stress and strengthening resilience, particularly in the isolated workplace settings often found in Australia.

72. Internal communication problems are a common complaint and paramedics have said they were left feeling isolated and at times helpless during periods of great personal stress. One can imagine the shock and perceived disrespect when a paramedic is confronted by the following [reported] comment:⁴³

“That’s the way it’s going to be - so suck it up. There are plenty more paramedics who are available to take your place ...”

Anonymous Manager <quoted>

73. Good employee morale thus should be among the key objectives of any employer, particularly where the workforce is prone to stressors that lead to a higher than normal incidence of Acute Stress Disorder (ASD) or PTSI/PTSD.

74. Evidence also suggests that daily, lower-level stressors may be related more closely to the development of psychological illnesses than isolated single critical incidents.

“... the day to day activities of the state’s police, firefighters and ambulance paramedics often created greater stress than that flowing from disasters...”

*The Toll of Trauma on Western Australian Emergency Staff and Volunteers
Report number 10, 27 September 2012
WA Parliament - Legislative Assembly*

75. The Australian Centre for Post-Traumatic Mental Health has noted that accumulated exposure to traumatic events, as opposed to exposure to a single significant incident, can manifest itself in serious psychological illness.⁴⁴ Poor morale and personal distress can thus lead to an insidious progression to more serious PTSI/PTSD, with the onset initiated by a series of lesser events including inappropriate management responses that corrode trust.

76. Clinical presentations of practitioner distress commonly result in a process of sensitisation, where repeated experiences of less traumatic incidents result in progressively more severe

⁴³ Bange, RF, *Enhancing Workplace Resilience: Identifying Issues and Improving Workforce Morale*, July 2015, Submission to the Independent Oversight Panel Into Workplace Culture and Well-Being at St John Ambulance Western Australia Ltd. (unpublished)

⁴⁴ Australian Centre for Post-Traumatic Mental Health, *Australian Guidelines for the Treatment of Acute Stress Disorder and Posttraumatic Stress Disorder* (2013), ACPMH, Melbourne, Victoria <http://bit.ly/1HWyyMo> accessed 13/06/2018

reactions over time. A related construct is that of kindling, where repeated exposure to traumatic events results in an increased responsivity, such that events that would not previously have affected the individual begin to trigger mental health symptoms.

77. Emergency services personnel in regional areas are likely to be affected by some incidents more than others depending on the extent to which a specific incident is personalised through identification with the environment, event or the victim. Sensitisation and personalisation play important roles in modifying the resilience and vulnerability of the individual.

78. The important issue is that unwarranted stressors and cultural factors within the workforce such as poor communication, bullying and harassment can be the cause or amplify the potential for mental distress and consequently adversely affect patient safety through practitioner impairment.

79. In his 2017 report on Bullying and Harassment at South East Coast Ambulance NHS Foundation Trust⁴⁵ Professor Duncan Lewis dissected the culture of the service. Many factors he identified are substantially reflected across the interviews by the author with dispatchers and other PSP. The author strongly commends the Lewis Report to the Inquiry (*Recommendation 1*).

6.6 - Which behaviour do employees find most difficult to deal with?

We also asked respondents to select the one behaviour they found most difficult to deal with. The principle behaviours (most frequently cited) are presented in rank order:

1. Being treated unfairly compared to others in your workplace
2. Your employer not following proper procedures
3. Being given an unmanageable workload or impossible deadlines
4. Being treated in a disrespectful or rude way
5. Having your views and opinions ignored
6. Someone continually checking up on you or your work when it is NOT necessary
7. Gossip and rumours being spread about you or having allegations made against you
8. Someone withholding information which affects your performance
9. Intimidating behaviour from people at work

These behaviours confirm their high prevalence rates as being troublesome for employees to deal with. Whilst some are difficult to address (workloads), others are much more easily dealt with. Courtesy, fair management, respectfulness and dealing professionally with inappropriate behaviour could address many of these behaviours at source. The key is recognising them and addressing them head on.

Figure 1. Extract from Lewis Report July 2017 (p 20), *Bullying and Harassment at South East Coast Ambulance NHS Foundation Trust: An Independent Report*

⁴⁵ Lewis D, *Bullying & Harassment at South East Coast Ambulance NHS Foundation Trust: An Independent Report*, Plymouth University & Longbow Associates Ltd, July 2017, <https://bit.ly/2xuYjUO> accessed 18/06/2018

80. The Lewis Report is but one instance of poor service culture. Other examples abound, with scathing reports on the culture within the London Ambulance Service^{46,47} and Toronto Paramedic Service.⁴⁸ On the other hand, the Ambulance Victoria⁴⁹ story shows the feasibility of a turnaround in culture given proactive leadership and appropriate resourcing.

81. Nonetheless, poor management practices and lack of contemporary mental health literacy are constantly raised as significant stress factors within the emergency and healthcare environments. In the majority of cases, the underlying causes of concern involve matters that stem from a culture that tolerates bullying and harassment.

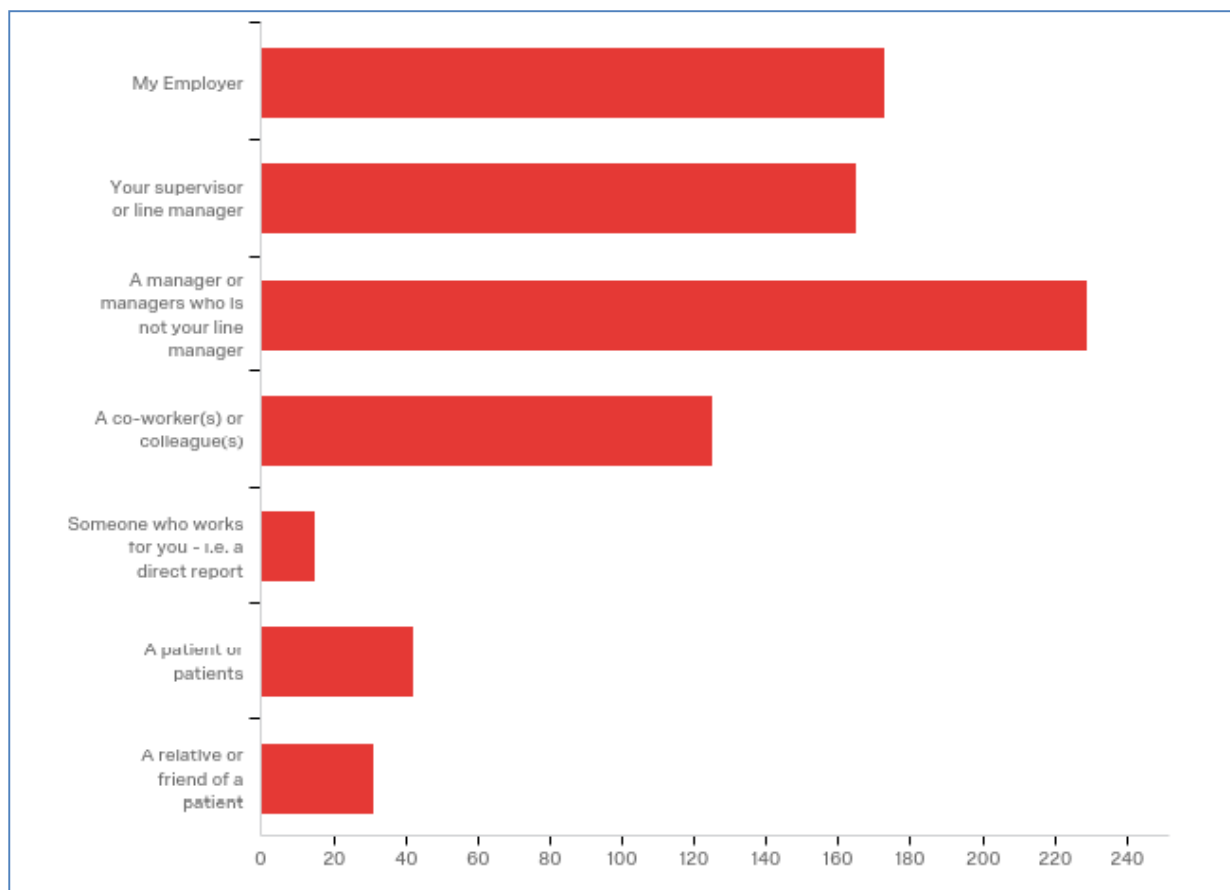


Figure 2: Perceived perpetrators for the behaviour employees found most difficult to deal with (Source: Lewis Report July 2017 (p 21), *Bullying and Harassment at South East Coast Ambulance NHS Foundation Trust: An Independent Report*)

⁴⁶ David Linsell, *London Ambulance has 'embedded culture of bullying and harassment', independent report finds*, This is Local London, 3 July 2015. <http://bit.ly/1Hq0Efi> accessed 12/06/2018

⁴⁷ Alison Twist, *London Ambulance Service: Bullying and Harassment Review*, Andrea Adams Consultancy, Warwickshire, November 2014. <http://bit.ly/1L278VR> accessed 12/06/2018

⁴⁸ Shawn Jeffords, *City to examine paramedics' low morale*, Toronto Sun, 11 June 2015. <http://t.co/apLc7nWcka> accessed 13/06/2018

⁴⁹ The Paramedic Observer, *Welcome leadership from Ambulance Victoria*, Facebook 25 June 2016 <https://bit.ly/2aTM71V> accessed 13/06/2018

82. The historical antecedents of paramedic services show a strong bias towards a paramilitary style of management and Figure 2 provides some insight into the sources of distress. It indicates that better training and development of middle level and supervisory staff may need to be a priority in changing the internal service cultures.

83. Why such cultures arise or are perpetuated is of concern. Internationally, paramedic services have been the 'poor cousin' in emergency and out-of-hospital care with working conditions and remuneration in many jurisdictions well below that of other health professions and not reflecting the education and training or the risk exposures faced by today's paramedic.

84. Emergency responses to flood, fire, and disaster situations commonly mobilise a greater proportion of volunteer staff. Volunteers are also more widely used in paramedic services than in other health services, especially in WA and the NT, which may lead to a different style of management that is less respectful and less individually accountable. The author reiterates that volunteers must not be forgotten in addressing the question of OSI.

85. The isolation of much out-of-hospital care from hospital and clinical work ('silos') has tended to hamper inter-professional understanding, with the result that paramedics have in many ways been 'the forgotten profession'. Lower education standards for entry to the profession and separate educational pathways with in-house training in the past are among other reasons advanced for the slow recognition of the role of paramedics as health practitioners along with nurses and doctors.

86. These latter factors should not apply to Australia where paramedics have been university-educated for many years, with a growing number of postgraduate-qualified practitioners and a burgeoning research output from doctoral and post-doctoral researchers.

87. However, different educational pathways may create significant barriers to understanding. To help offset that eventuality, the author strongly supports tertiary education with inter-professional education and training as the best route to qualification and as a facilitator of later inter-professional and team-based practice that will benefit patients.

88. Similarly, the presence of paramedic expertise within the organisational policy structure of health and emergency governance frameworks is strongly supported. Such a presence has the potential to enhance consideration of the unique issues related to paramedic services and foster the mobilisation of paramedics in providing community care and outreach programs. The opportunities for new models of care include health care in the home, initial and on-going care for mental health and addiction as well as the better-known emergency trauma care. To date, only Victoria⁵⁰ has a Chief Paramedic Officer, whereas Chief Medical Officers and Chief Nurses are routine appointments intended to drive clinical and practice leadership.

89. Despite the reputation of paramedic services for having a top-down and command-style management, there are many reasons why an employee will join and choose to stay with an organisation even when there is a mentally destructive environment. These include the altruism of paramedics and volunteers, the geographic location with housing, school and other family commitments, as well as for financial and career reasons.

⁵⁰ The Paramedic Observer, *Chief Paramedic appointment heralds new era*, Facebook, 13 April 2017.
<https://bit.ly/2opZMUO> accessed 18/06/2018

90. A seldom-mentioned factor in the interplay between services, management and paramedics is the past absence of national paramedic registration. That situation had the practical effect of making public-funded paramedic services the entities responsible for recognition of a person as a paramedic. It also opened up avenues for subtle (and more overt) bullying and intimidation.

91. While employees normally have flexibility in changing employers, this option is relatively infeasible for paramedics who are not independently registered health professionals. Staff retention alone is thus not a good indicator of satisfaction where there is an unrealistic prospect of obtaining other employment. Not surprisingly, this imbalance of power is commonly cited as placing stress on paramedics in their relationships with supervisors and managers.

92. Other ramifications from the absence of independent registration include the intermingling of disciplinary and fitness-to-practice issues; the lack of independent public engagement and transparency in determining fitness-to-practice; the inherent dangers of conflict of interest, and the potential variations in investigation standards and outcomes. Paramedics have spoken about how managers have taken action against individuals that has been disproportionate to the issue at hand and inconsistent with how the policy or procedure is intended to be applied. These factors all add to the commonly-described atmosphere of fear and the general unwillingness of paramedics to speak out.⁵¹

93. The advent of independent paramedic registration⁵² under the Health Practitioner Regulation National Law should do much to overcome these aspects – albeit the author has reservations about the situation in NSW⁵³ where the health complaints process (still to be finalised) may be dominated by having members drawn from a single employer and therefore not at arm's length.

94. How to remove or diminish embedded attitudes and the stigma attached to any display of weakness or mental impairment remains a primary challenge. Overcoming these attitudes and creating a strong positive culture will be a lengthy process and begins with education and understanding of mental health at an early career stage as well as proactive moves for cultural change. There is no place in paramedic services for bullies, and managers and psychological support staff must be seen to 'walk the talk' within the field so they understand the work environment and their presence becomes a natural event and not just when things go wrong.

95. The essential lesson to take from this background is that the creation and maintenance of good morale and healthy work culture are vital. It is also a complex undertaking that demands a broad-based approach. It relies greatly on leadership at all levels, beginning with the 'tone at the top' from Governing Boards, Chief Executives and senior staff.

96. All aspects of stress within the workplace should be reviewed on a regular basis with real action taken on identified issues. Effective communication channels must be fostered that recognise the skills and inputs of a professional workforce. Practitioners and employee representatives (unions, professional associations) should have input into the process to ensure transparency and 'ownership' of the outcomes.

⁵¹ The Paramedic Observer, *Freedom to speak up*, Facebook 9 April 2016, <https://bit.ly/2u9zmws> accessed 21/06/2018

⁵² The Paramedicine Board of Australia <http://www.paramedicineboard.gov.au/> accessed 21/06/2018

⁵³ The Paramedic Observer, *The co-regulation of paramedicine in NSW*, 17 January 2018, <http://bit.ly/2DdCLLr> accessed 21/06/2018

97. An overarching strategy is needed to guide initiatives that will promote staff psychological health, minimise psychological harm due to workplace factors and support measures to maintain good mental health. As a start, internal support might follow the Australian Guidelines for the Treatment of Acute Stress Disorder and Posttraumatic Stress Disorder (Australian Centre for Posttraumatic Mental Health, 2013). The psychological health of the workforce should be an accountable performance issue and reportable outcome in service reports, as well as a factor for assessment in provider accreditation.

98. In the absence of registration, consolidated research data on drug misuse and mental health are not readily available. Data from public domain sources such as Coronial inquiries is available, but that may represent only the tip of the iceberg.

99. This dearth of reliable data may be a consequence of inadequate transparency under the existing regulatory arrangements and the internalisation of investigations and remedial actions taken by the major employers of paramedics – the public ambulance services. The past stigma attached to mental health issues is also claimed to militate against more open discussion of mental distress. There is (anecdotally) a reluctance to declare difficulties due to a fear of bullying or reprisals coupled with the absence of independent reporting mechanisms, including formal external reporting. Internal anonymous ‘help’ or ‘hot’ lines with specialist help attuned to the circumstances of the profession may assist those suffering distress or reporting grievances.

100. Regardless of the causes, much data collected on emergency services is focused on service activities and not practitioners. That limits the amount of available workforce information which is pivotal to understanding the structure of the workforce, the state of practitioner well-being and the flows into and out of the workforce in both employed and private practice.

101. The advent of paramedic registration is expected to bring needed change, with reliable statistics becoming available on the practitioner cohort as well as information on fitness to practice and reporting of physical and mental health status where it is likely to affect the quality of care. That will still leave much distress unknown unless effective internal systems are in place.

102. When dealing with mental health and suicide of practitioners, statistics alone do not tell the full story. Any occurrence of harm is deeply regrettable - with the negative impacts felt most keenly by those closest to the event – and affecting not only the practitioner, colleagues and their families, but also the patients. The toll of vicarious trauma can be significant and insidious, and direct access to the services of internal or contracted mental health professionals should be made available to all staff (including volunteers), their partners and immediate families.

103. Research on paramedic mental impairment should build on existing resources. However, the emergency agencies attend the same critical incidents (e.g. motor vehicle accidents, flood, fire, earthquake) and train to support each other through joint disaster training exercises. They use similar processes in delivering resiliency and other programs to address issues of trauma and mental distress to the police, firefighters, paramedics and volunteers.

104. What is needed is a significant, national, diverse and inclusive sample of PSP assessed using broadly-accepted and validated screening measures, which might be obtained by a national approach encompassing all first responder populations. There should be economies of scale if the emergency agencies were to combine to jointly deliver their welfare programs aimed at identifying and responding to staff mental distress. Effective strategies developed by any service also should be disseminated and adopted where feasible.

PROVIDER OVERSIGHT AND ACCREDITATION

105. Because paramedic services fulfil a key function in public health and safety and the health services are funded through the taxpayer, their accountability needs to be commensurate with that role. That mandates an appropriate level of independent oversight⁵⁴ that is not provided by the RoGS or limited transparency through an annual report or the lens of a health department.

106. To achieve suitable oversight objectives, the author opines that it is time for all paramedic service providers in Australia to be subject to an independent accreditation⁵⁵ and quality assurance regime that will regulate service providers in the public interest, and complement the regulatory rigour that will be provided by paramedic registration.

107. A national Standard for paramedic services is proposed, together with the creation of a monitoring body with powers similar to those of the Care Quality Commission⁵⁶ in the United Kingdom. This may be done in association with reviews of existing Acts regulating health and ambulance services and the implementation of suitable legislation covering paramedic services in WA and the NT which currently have no specific Ambulance Act or equivalent.

108. If the public-funded services in WA and the NT remain as contracted private services, legislation should be enacted to recognise their role as public bodies to bring them under public sector ethical standards and subject to the purview of integrity agencies such as the WA Corruption and Crime Commission.

109. Recent legislation establishing the NT Independent Commission Against Corruption⁵⁷ already contains powers to capture all persons performing services on behalf of the NT Government, regardless of whether they're retained as contractors or public sector employees. A similar amendment could be embodied in relevant WA legislation.

THE POTENTIAL FOR DRUG ABUSE

110. The vast majority of paramedics conduct themselves with integrity and professionalism. However, a small number of paramedics have been known to steal and misuse addictive drugs⁵⁸ such as fentanyl, to satisfy an addiction or relieve conditions like PTSI/PTSD. According to the Australian broadcaster ABC, there have been almost 100 investigations into cases involving paramedics misappropriating addictive drugs in the last eight years.

111. The *Suicide by health professionals* study⁵⁹ showed the clear need for targeted prevention of suicide by health professionals and that the rate of suicide was higher for health professionals

⁵⁴ The Paramedic Observer, Review head calls for rigorous oversight, Facebook 19 September 2016, <https://bit.ly/2dlLdQp> accessed 21/06/2018

⁵⁵ The Paramedic Observer, *CQC to regulate independent health services*, Facebook 14 February 2018, <https://bit.ly/2K6ezhp> accessed 21/06/2018

⁵⁶ The Paramedic Observer, *The Regulation of Paramedic (aka Ambulance) Service Providers*, Facebook 10 December 2015, <https://bit.ly/1nZKzYG> accessed 21/06/2018

⁵⁷ Michaels M, Spain M, Newman S, *Independent Commissioner against Corruption to be established for the Northern Territory*, Clayton Utz, Darwin, 29 March 2018, <https://bit.ly/2MMRCSe> accessed 21/06/2018

⁵⁸ ABC News, *Saving our lives while losing their own – the rise of narcotics use among paramedics*, Australian Broadcasting Commission, Sydney, 24 May 2018. <https://ab.co/2HhUOMS> accessed 21/06/2018

⁵⁹ Allison J Milner, Humaira Maheen, Marie M Bismark and Matthew J Spittal, *Suicide by health professionals: a retrospective mortality study in Australia, 2001–2012*, *Med J Aust* 2016; 205 (6): 260-265. doi: 10.5694/mja15.01044

with access to prescription medicines - which sends a clear warning for paramedic services where powerful restricted drugs are available and mental distress is a known occupational factor.

112. In Victoria, the Independent Broad-based Anti-Corruption Commission conducted a two-year investigation (Operation Tone) into alleged corruption and illicit drug use among members of the state's ambulance service.⁶⁰ The value of this investigation lies in the collation of case histories, identification of risks and the suite of prevention and risk mitigation recommendations which can be applied to any service provider.

113. Notable among the Commission's proposed responses is the provision of appropriate welfare and support arrangements for employees who appear to be using illicit drugs or drugs of dependence. That highlights the importance of early warning indicators of mental distress and the value of interpersonal communications in providing behavioural support.

114. Other health practitioners and services are also at risk and the WA Corruption and Crime Commission on 25 May 2018 tabled its Report⁶¹ to Parliament on serious misconduct risks around dangerous drugs in hospitals and the management of dangerous drugs and the issue of theft and misuse of addictive pharmaceuticals in WA hospitals. The author has independently investigated the security of drug use and storage within health and believes this is an area where all services need to examine the integrity of their drug management controls.

THE EDUCATION OF PARAMEDICS

115. Interviews with paramedics disclose that they perceive a substantial stigma attached to mental health and opioid addiction from within the community, law enforcement, media and health sectors. The reasons are several, including the fact that mental health and addiction issues are often not part of the educational curriculum.

116. Among the important factors in the treatment of mental health and addiction, is the availability of universal services and pathways to ensure care becomes more accessible, more flexible and more responsive at the earliest stage feasible, and which can be utilised by paramedics and other practitioners rather than using emergency departments as the default care portal for all cases of illness and injury.

117. Internationally, health and public safety organisations are developing awareness programs, but anecdotal reports and media attention indicate there's still a lot of ignorance. A new report by The King's Fund⁶² found that valuable progress had been made in removing the barriers between mental health and other parts of the health system but much also remains to be done to embed mental health fully into integrated care teams, urgent and emergency care pathways.

19 September 2016, <https://www.mja.com.au/journal/2016/205/6/suicide-health-professionals-retrospective-mortality-study-australia-2001-2012> accessed 03/06/2018

⁶⁰ Independent Broad-based Anti-corruption Commission, *Operation Tone: Special report concerning drug use and associated corrupt conduct involving Ambulance Victoria paramedics*, September 2017. ISBN 978-0-6481624-3-8 (print) ISBN 978-0-6481624-2-1 (online) <http://bit.ly/2yiKC8a> accessed 03/06/2018

⁶¹ Corruption and Crime Commission, *Report on serious misconduct risks around dangerous drugs in hospitals*, Western Australian Government, 25 May 2018, <https://bit.ly/2ytHTgp> accessed 21/06/2018

⁶² Naylor C, Taggart H, Charles A, *Mental health and new models of care: Lessons from the vanguards*, May 2017, The King's Fund, London, <https://bit.ly/2JXCWsk> accessed 21/06/2018

118. Given a change in focus and opportunities for referral, comes the need for a good understanding of the patient and his or her presentation. In proposing nine principles for success in integrating mental health into new models of care the King's Fund study authors highlighted that all frontline staff should receive appropriate training in mental health, regardless of the setting in which they work.

119. While it is common for paramedics to have seen and dealt with mental health issues and treated drug overdoses in the field, not all have seen the aftermath of withdrawal and longer-term treatment. Many paramedics admit to some ignorance and a lack of education. Others take a particular interest as part of later specialist education and continuing professional development.

120. Paramedics are increasingly challenged in the workplace by addiction (in several forms) which may lead to highly stressful incidents, onlooker assault and patient death. Coping with those events may prove difficult. What paramedics need is improved knowledge of mental health conditions and drug addiction and how that affects patients. As a start, any sense of stigma needs to be cast aside when it comes to treatment.

121. Structured development of awareness during initial education can be a valuable introduction to the issues involved—for example, why [opioid] addicts do the things they do and why they get angry or lash out during or after treatment. To achieve better outcomes, the author opines that paramedics (in concert with other groups) need better insights into what's going on with their patients and how painful it is if the patients are not on a drug, and why they go to the extremes that they do to remain on the drug. These insights might be reinforced through practicum placements that meet the standards set for agencies (ambulance services) that provide mandated clinical training⁶³ as an accreditation requirement.

122. Significantly, paramedics need to develop awareness of how occupational stress and vicarious trauma can affect them as practitioners. It's so important that in 2017 the World Medical Association included self-care as part of their Physician's Pledge in revising the Declaration of Geneva.

123. The Physician's Pledge is the modern version of the Hippocratic Oath, and the latest revision includes a requirement for physicians to attend to their own health, well-being and abilities^{64, 65} to provide care of the highest standard. The author opines that this self-care principle reflects common sense and is equally applicable to paramedics and other health professionals.

124. Resilience training, mindfulness & coaching are commonly advanced as solutions to practitioner mental health problems, but care needs to be taken in the focus applied. The way the word 'resilience' is commonly used implies there is nothing wrong with the work environment and culture, and it also places a negative moral value judgement on those who may be struggling.

⁶³ Brightwell R, Sim, M, Lord, B, Maguire, B, Holmes, L. *Standards and quality indicators for best practice in paramedic and inter-professional experiential practica*. Sydney: Office for Teaching and Learning; 2015.

⁶⁴ World Medical Association, *Modern physicians' pledge approved by World Medical Association*, October 2017 <https://bit.ly/2gbF7QQ> accessed 21/06/2018

⁶⁵ World Medical Association, *WMA Declaration of Geneva*, October 2017, <https://bit.ly/2yosyvo> accessed 21/06/2018

125. There is a pejorative implication that burnout and mental distress, which may result from (say) excessive workloads and fatigue or bullying, are predominantly attributable to individual weakness. That attitude may lead to abrogation of the organisational responsibility to engender a safe, sustainable workplace environment. It would be a fundamental failure of ethical leadership.

126. A better understanding of mental health and addiction is also not helped by populist political campaigns and media attention which focus on 'law and order' themes with only limited supporting evidence for policy directions.

127. Another factor that may hamper understanding within the paramedic profession is that as newly qualified paramedics enter the workforce, they are 'socialised' by the culture of the organisation and by older colleagues who may have a stigma about (say) drug addiction or mental health. This socialisation or 'the way we do it here' applies across many professions.

128. The answer is to forestall misinformation and stigmatisation by developing awareness and mental literacy at an early career stage through undergraduate units and service induction programs, as well as professional continuing education programs. Clinician engagement in these programs can be very effective through the lessons of lived experience and peer influence. Some advocates have achieved considerable success in addiction awareness and recovery by using the example of lived experience delivered through recovering addicts rather than using fear campaigns with stereotypical 'crackhead' depictions. The same applies to mental health, with some of the most compelling lessons coming from those who have recovered from a psychological injury.

RECOGNITION, RECOVERY AND REDRESS

129. While damage to mental health is now generally accepted as a potential outcome of military activities, changing the attitudes towards workforce stress in other occupations has been slow to evolve. In many jurisdictions, there is no presumptive legislation that would acknowledge the significant risk of psychological illness in paramedics.

130. Demonstrating work-related mental harm can be an onerous process for someone who is already in jeopardy. One of the constant refrains has been a concern at the compensation processes, with delays, multiple assessments, and invasions of privacy. Paramedics have said that the stigma involved in declaring distress and gaining recognition of harm, and the perceived difficulties in obtaining redress through external mechanisms such as workers compensation, tend to inhibit reporting and contribute to overall stress.

131 That fear of disclosure must be overcome through better internal processes and better compensation mechanisms that recognise the nature of psychological harm and which provide support for practitioners from the earliest stages without having other external ramifications.

132. The Public Interest Advocacy Centre has highlighted⁶⁶ widespread, systemic discrimination by insurers on the basis of mental health, with discriminatory practices particularly prevalent in relation to life, income-protection, total and permanent disability and travel insurance policies. The Centre has been working with BeyondBlue, Mental Health Australia and Victoria Legal Aid for a number of years to get insurance companies to improve their policies.

⁶⁶ Public Interest Advocacy Centre Ltd, *Mental Health and Insurance, Submission to Royal Commission into Misconduct in the Banking, Superannuation and Financial Services Industry*, 26 April 2018, <https://bit.ly/2ldBKo6> accessed 21/06/2018

133. The evidence shows clients have been refused cover, had their claims declined or faced unreasonably broad exclusions and significant additional premiums as a result of disclosing a mental illness or a history of mental illness, including short episodes of anxiety or depression.

134. Many paramedics have spoken about the difficulties in having issues examined promptly, and the perceived struggle in having matters resolved with various evaluation bodies and insurers. The processes are commonly perceived as being traumatic and burdensome rather than evaluative and supportive. Too often the manner in which individuals are forced to relive the harrowing ordeal of their experiences leads to even greater distress.

135. At the least, occupational health and safety legislation and contractual definitions of 'health' must include psychological health, and the level of compensation received should be no less favourable for those suffering mental distress than for those who receive a physical injury. This situation will require a sea-change in attitudes, not only within the service environment and among colleagues but also a much greater awareness and understanding of mental health by those dealing with treatment, insurance and compensation issues.

"There needs to be a seismic shift in insurers' thinking when it comes to people seeking early intervention for mental health conditions Too often consumers are discouraged from seeking support and early intervention for mental health conditions out of fear it will affect their ability to insure themselves, their families and their livelihoods against unforeseen circumstances. "

*Georgie Harman
Chief Officer- BeyondBlue*

136. Several independent investigations have shown disreputable practices in dealing with both physical and mental harm. In 2016 Victoria's Ombudsman⁶⁷ found that insurance agents working for WorkSafe Victoria were "gaming the system" for financial incentives by unfairly denying payments to injured workers. The workers' compensation system had "failed some particularly vulnerable people" according to Ombudsman Deborah Glass.

137. The struggle for recognition and compensation has been eased in some jurisdictions which has seen legislation for the presumptive recognition of PTSI/PTSD in Alberta, Ontario and Manitoba⁶⁸ which have all amended their workers' compensation legislation to enable the presumption that PTSI/PTSD is a workplace injury among first responders - thus removing the onus on emergency workers to prove a connection between their diagnosis and their job.

138. The use of private insurers for compensation issues needs consideration of their ethical and probity standards under a business model which appears aligned to profit and cost (claim) minimisation rather than 'neutral' underwriting outcomes. This concern extends to the conflicts of interest, moral risks and fraud and corruption opportunities created by a system where financial rewards and penalties drive performance, and unreasonable decisions may result in people being injured again by the system.⁶⁹ The Ombudsman's report reinforces those concerns.

⁶⁷ Victorian Ombudsman, *Investigation into the management of complex workers compensation claims and WorkSafe oversight*, September 2016, <http://bit.ly/2cpvxt3> accessed 18/06/2018

⁶⁸ Legislative Assembly of Manitoba, Bill 35 – The WorkersCompensation Amendment Act (Presumption Repest-Traumatic Stress Disorder and Other Amendments) <http://bit.ly/1dYvmBX> accessed 18/06/2018

⁶⁹ The Paramedic Observer, *Damage accentuation, repair or mitigation?*, Facebook, 6 March 2016, <http://bit.ly/2a3u0c3> accessed 16/06/2018

139. The difficulties in obtaining a sensitive and independent evaluation of compensation for mental and physical injury is by no means unique to paramedics and Australia, and in Ontario, a recent report drew attention to concerns about alleged Workplace Safety and Insurance Board (WSIB) interference in the medical care of injured workers.⁷⁰ Other compensation cases reported in Australia by Four Corners (and other investigations) also give cause for alarm (not cited).

140. What is clear is that the system of compensation needs to be driven not by profit, but by demonstrated need based upon an objective and independent assessment of injury and prognosis of outcomes. Moreover, just as corporate legislation can be uniform in Australia, so too should compensation law be harmonised across all jurisdictions.

OTHER MATTERS – RESOURCE LEVELS

141. Service errors occur, and even with excellent care, people die. This is greatly distressing for the parties involved and politically unpalatable. The public puts pressure on politicians, and the process continues until it reaches the level of the practitioners with managers challenged to get more and more performance out of staff in the face of ever-increasing demands and expectations.

142. Performance and morale are not bolstered, and trust is not engendered by managers who may bully the (often) stressed paramedics by saying [as reported];

“...Paramedics are overpaid ... and community paramedics even more so ...”

Anonymous Manager <quoted>

The common outcomes of such behaviour are serious breakdowns in trust, workplace stress, reduced productivity, higher risks of performance failures, and increased patient risk.

143. The persistent message conveyed to the author when discussing service operations is the desire to have enough staff and resources so the paramedics and other staff can perform the roles they love. They want some downtime between calls to maintain their mental well-being and a quiet space^{71,72,73} in which to recover and ‘decompress’ when needed. They want some respite from the physical and mental fatigue they suffer as a result of long hours and high-intensity shift work. Dispatchers also need a quiet space in which to reflect and potentially talk to mentors. Meeting those goals essentially means resourcing paramedic services adequately.

144. The reality is that paramedic services cannot be run on the cheap if properly resourced and staffed, and the community (represented by government) needs to be honest in the levels of expected service and whether the pressure to perform with limited resources justifies the horrendous human toll on paramedics, their families and other workers who are only human.

⁷⁰ Ontario Federation of Labour, *Whistleblower Report Exposes WSIB Interference in Medical Care: Doctors Allege Injured Workers are Re-Victimized by the Compensation System*, 5 November 2015, bit.ly/1HDiY8V accessed 18/06/2018

⁷¹ Jason Shueh, *NYC's new 911 center has quiet rooms for decompressing after stressful calls*, StateScoop, 24 May 2017, <https://bit.ly/2tuObXi> accessed 21/06/2018

⁷² Tiara Green, *Dallas Police have a 'quiet room' dedicated for employees under stress*, The CW33, 17 May 2018, <https://bit.ly/2tuLepJ> accessed 21/06/2018

⁷³ Troy Parks, *Physicians take to "reset room" to battle burnout*, AMA Wire, 8 June 2016, <https://bit.ly/2McCkox> accessed 21/06/2018

145. The answer lies with investment into the system - which is currently a hodgepodge of public agencies, private contractors and mixed funding models. Across the major government-funded paramedic services in Australia there are no governing bodies that oversee what resources are required to service the community or the standards of performance to be met. That is not to say Australian paramedic services are poor – quite the contrary – they are among the best in the world, but there is no independent monitor of performance.

“Chief wellness officers won’t reduce burnout. What will reduce burnout? Appropriate staffing - Fewer clinical hours - Functional EMR - Non-physician help to do busywork - Scribes - \$\$ for charting done outside of clinical hours.”

Jennifer Chuang, MD

146. Treating health care as an integrated and inter-dependent system is important because the ability of paramedic services to meet community demands depends on the *available* resources at any time, and that can be greatly affected by the capacity of the hospital, clinic and referral pathways to accommodate the patient load. This interconnection of service roles has also helped drive new models of care in the UK^{74,75} and Australia.^{76,77}

147. Resource allocations and adequate funding of health care are crucial, and it is inexplicable that the Federal government does not take greater responsibility for base funding of the out of hospital health care provided by paramedic services. Many of the health interventions performed by paramedics would be covered by Medicare if they were performed in a public hospital or by a health professional with a Medicare provider number. A National Health Care Commission⁷⁸ could drive reform in these areas by taking a ‘whole of system’ approach to health funding and by facilitating the effective mobilisation of the available health workforce including paramedics.

148. Adequate funding of hospital services for emergency trauma and mental health pathways has the potential to provide better access for patients that would reduce the excessive ‘patient stacking’ via ‘ramping’ of ambulances⁷⁹ that is a too regular occurrence. Ramping affects patient care and service capacity with knock-on stress and fatigue that reduces morale.

149. The frustration caused by ramping delays which deprive areas of resources for emergency calls is another sometimes forgotten external stressor for paramedics (and dispatchers). Attending crews must cope with patients who deteriorate in the extra time it takes to respond, which can cause a wide range of emotional responses. Crews face anger and disappointment on-scene as people may have had to wait for a longer period. It also forces staff into overtime - further increasing practitioner stress (due to missed family commitments and fatigue).

⁷⁴ Welsh Government, *Green light for highly successful blue light model*, Welsh Government, 27 February, 2017. <https://bit.ly/2MioyAQ> accessed 22/06/2018

⁷⁵ The Paramedic Observer, *Major changes to UK ambulance response standards*, Facebook, 15 July 2017. <https://bit.ly/2tTOfib> accessed 22/06/2018

⁷⁶ Ambulance Victoria, *Delivering our patients the right care, at the right time, at the right place - Revised Clinical Response Model Evaluation Report, June 2017*, Ambulance Victoria, Doncaster, Victoria <https://bit.ly/2shFgqg> accessed 22/06/2018

⁷⁷ The Paramedic Observer, *An international trend to review service models*, Facebook 1 October 2017. <https://bit.ly/2fBz4F4> accessed 22/06/2018

⁷⁸ Dwyer J, *Health care reform- Part 2*, John Menadue – Pearls and Irritations Blog, 20 June 2018, <https://bit.ly/2K1bdj5> accessed 22/06/2018

⁷⁹ The Paramedic Observer, *The hidden toll of ambulance delays*, Facebook 5 April 2018. <https://bit.ly/2tpCkuy> accessed 22/06/2018

150. Research in Europe, Canada and the United States has developed guidelines for staffing levels within the registered Ambulance Services by governing bodies. In Australia, there are no public guidelines and no formal independent oversight that might be provided by a suitable national Standard or system of accreditation for paramedic services.

151. The author opines that it's important to reach a consensus about the personnel mix in paramedic service delivery which may see more technician level roles explored, along with advanced paramedic clinical roles, depending on the supporting health infrastructure in urban, regional or remote locations. It's a feasible issue, and examples of defined minimum standards in health staffing are provided by the Safe Patient Care (Nurse to Patient and Midwife to Patient Ratios) Act 2015 of Victoria⁸⁰ and legislated ratios in Queensland.⁸¹

152. A related resource matter is the capacity of the public out of hospital emergency care system to meet urgent surge demands or disaster situations. With the paramedic workforce soon to be a registered health profession, the engagement of registered practitioners should have a positive impact on staffing of service providers and professional relationships, since the competencies and fitness to practice are based on the status of the practitioner regardless of their employment.

153. Registration has the potential to foster better morale and generate mutual respect and recognition of the quality of care in joint service operations. Opportunities will be presented to develop harmonised standards of practice so that public sector and private sector practitioners can work together with greater confidence in the knowledge that the level of care will meet appropriate standards and facilitate a seamless and consistent level of service across operational interfaces. This may affect the way in which events and workplace support are provided, by enabling expert paramedic level treatment on site that avoids unnecessary emergency response.

154. Such developments hold the prospect that some major private operators (and the military) would have the capability of supporting full-service emergency operations which can be utilised for surge, disaster and mass casualty incidents to supplement public sector services.⁸² Private services already provide aeromedical services and full-service operations in WA and the NT, and it is common overseas in the US, Canada and the United Kingdom.

155. It's not so much a question of capability, but whether there is a willingness to explore the necessary legislative and operational changes to make this interoperability a reality through suitable joint training and simulation operations and independent accreditation of all paramedic service providers.

⁸⁰ Victoria Health, *Safe Patient Care (Nurse to Patient and Midwife to Patient Ratios) Act 2015*, Victoria State Government, 1 September 2015. <https://bit.ly/2IAI3JP> accessed 22/06/2018 (Also see <https://bit.ly/2lwwGOE>)

⁸¹ Office of the Chief Nursing and Midwifery Officer, *Nurse-to-patient ratios: frequently asked questions*, Queensland Health, Brisbane, Australia, May 2016 <https://bit.ly/2K8ddqi> accessed 22/06/2018

⁸² Bange RF, *Paramedic Registration and Service Providers*, Australian Paramedic, Edition1, 2018, Emergency Media, Melbourne, Australia. <https://bit.ly/2MT0NR3> accessed 22/06/2018

OTHER MATTERS – FATIGUE

156. Practitioner fatigue is another threat to well-being that is often overlooked as being ‘just part of the job’. Mental and physical fatigue⁸³ has been linked to personnel injury, patient care error, and adverse events - and the number of fatigue-related safety incidents involving paramedics and their patients appears to be on the rise.

157. The US shows the impact of poor fatigue management. Across the US it’s not uncommon to find paramedics working extended overtime shifts and having more than one job to a much greater extent than in Australia. Fatigued paramedics are as bad as intoxicated or texting drivers and the US paramedics have more ambulance accidents,⁸⁴ they commit more clinical errors, experience more injuries and are more likely to be killed or injured on the way home.

158. The industry has a fatigue problem, and recent research⁸⁵ shows that more than half of US emergency services staff report severe mental and physical fatigue while at work, poor sleep quality, and poor recovery between shifts. To help overcome the problem of fatigue, the US National Association of State EMS Officials has partnered with a team from the University of Pittsburgh School of Medicine and developed new Evidence-Based Guidelines⁸⁶ intended to help normalise practice and policies, and to aid decision-making based on a review of the best available evidence tailored to EMS operations.

159. The key objective is to implement workplace strategies that are effective in minimising the physical and mental risks posed by fatigue. There is a gap in understanding the impact of shift work and sleep disorders on the mental health and workplace decision-making of paramedics and research continues.^{87,88,89} Good fatigue management has critical implications for public safety and the health of PSP, and guidelines can help inform policymakers in positions of leadership, including those responsible for administrative, rostering and management roles.

160. Fatigue guidelines through a national Standard should also guide the decision making of individuals in the position of educating, training, and influencing policies that impact the work environment, health, and safety of PSP. Ultimately, fatigue risk management is a shared responsibility between the employer and employee and fatigue recommendations are also meant to inform PSP and to guide their decision-making in self-awareness and fatigue management.

⁸³ Pyper Z, Paterson J, *Fatigue and mental health in Australian rural and regional ambulance personnel*, Emergency Medicine Australasia, Vol 28, Issue 1, 15 December 2015 <https://doi.org/10.1111/1742-6723.12520> accessed 22/06/2018

⁸⁴ The Paramedic Observer, *EMS safety and vehicle incidents*, Facebook 11 March 2018. <https://bit.ly/2KkWmNm> accessed 22/06/2018

⁸⁵ NAEMT News, *Fatigue in EMS Risk Management Guidelines Go Live*, National Association of Emergency Medical Technicians, 12 January 2018. <http://bit.ly/2FztKxQ> accessed 22/06/2018

⁸⁶ Patterson PD et al, *Evidence-Based Guidelines for Fatigue Risk Management in Emergency Medical Services*, Prehospital Emergency Care, 22:sup1, 89-101, DOI: 10.1080/10903127.2017.1376137 accessed 22/06/2018

⁸⁷ Jackson M, Conduit R, *The relationship between shift-work, sleep and mental health among paramedics in Australia and Saudi Arabia*, RMIT University Research Survey March 2018 <https://bit.ly/2ECm1xG> accessed 22/06/2018

⁸⁸ Courtney JA, *Fatigue and Mental Health in Ambulance Paramedic Shiftworkers*, PhD Thesis, School of Psychological Science, LaTrobe University, October 2010. <https://tinyurl.com/ybr89pap> accessed 22/06/2018

⁸⁹ Rawat V, Dawson D, Schilders M, & Kennedy, G. A. (2015) *Sleep disturbances among Victorian paramedics and the impact of demographic and biopsychosocial factors*, 11th Annual Congress of the Australasian Chronobiology Society, Melbourne, Australia, (ISN978-0-64656274-2). <https://tinyurl.com/yblcyf5z> accessed Jun 24 2018

OTHER MATTERS – ASSAULT

161. Considerable concern has been raised by the number of cases of abuse and physical assault against PSP. One of the outcomes has been strident calls for mandatory (no option) custodial penalties for offences committed within the health and care and law enforcement domains.⁹⁰ Paramedics have been at the forefront in making these calls and have pointed to the serious mental and physical harm inflicted on practitioners.

162. The author condemns such assaults and encourages campaigns designed to prevent assault. He also supports appropriate custodial sentences for perpetrators provided they allow for judicial discretion. This view is informed by evidence-based research on sentencing and recidivism which shows limited correlation between incarceration and the prevention of unpremeditated assault.

163. Ultimately, effective rehabilitation remains the only certain way of permanently protecting society from a particular offender since most offenders will not remain in prison forever (excepting for a very few limited categories). The best guarantee of specific deterrence is the successful re-integration of the offender into the community and not to fill jails with prisoners.

164. Judges are charged with being impartial decision makers who interpret the law and assess the full scope of available evidence before making a determination. Their role places them in a better position to ensure that justice is served through a greater understanding of the context of an offence whereas legislation mandating no-option custodial sentences cannot make allowances for the circumstances associated with the case in question. Judicial discretion has a purpose and should be enabled in special circumstances.

165. Currently, many measures are being explored to protect first responders including the use of scene withdrawal, highlighting high-risk zones, police escorts, duress alarms, vehicle and body cameras, training in situational awareness and self-defence, use of personal protective equipment, stab vests etc., as well as public information programs through various media campaigns. These measures should continue, with sharing of information on the outcomes.

166. Longer term, the community must deal with causes and not symptoms, and the most important objective is to prevent an assault in the first instance. That means examining the social determinants that influence behaviours and the available strategies to foster prevention from an early stage. One must not ignore the social determinants that create significant inequalities, homelessness and other social conditions that may predispose certain groups to embrace violence. The author therefore strongly supports investment in social measures for a just society that will reduce inequalities and foster better mental and physical health - leading to a less violent society.

167. Based on research and observed evidence, policies relating to physical and mental health and wellbeing, therefore, should be considered alongside other economic policies that will have a major impact on disadvantaged groups and marginalised populations. Healthy, engaged people and communities will be crucial in achieving a prosperous future, and a focus should be placed on policies founded on evidence (for example - what works in other jurisdictions).

⁹⁰ Richard Willingham, James Oaten, *Victorian Government to overhaul sentencing laws, promising more criminals will go to jail*, ABC News, 22 May 2018. <https://ab.co/2GJPWV8> accessed 21/06/2018

168. It's worth noting the pioneering policy developments in Wales and the *Well-being of Future Generations (Wales) Act 2015*.⁹¹ Among other things, the Act's seven well-being goals aim to make Wales a healthier place, where physical and mental well-being are maximised and in which choices and behaviours that benefit future health are understood.⁹²

169. A ground-breaking feature is that the Act puts Health Impact Assessments (HIAs) on a statutory footing and makes Wales the first country in the world to have statutory HIAs. Currently, only the Australian state of Tasmania and the Canadian provinces of Quebec and British Columbia are believed to have mandatory HIAs. HIAs provide an early assessment of the effects of proposed actions by public bodies on human health. It's a "health in all policies" approach that seeks to maximise the positive health effects of any proposed action and put forward proposals to mitigate the negative effects.

170. The law will apply to the Welsh government, local authorities and local health boards, and they will be required to publish their HIAs and take account of them when making decisions. HIA guardianship comes under a statutory Future Generations Commissioner.⁹³

171. Australia has a range of regulatory impact processes⁹⁴ through its various consultation and committee stages at departmental and Parliamentary levels. However, the distinction is that instead of financial or environmental impact, the underlying principle of the Wales strategy is the consideration of health and wellbeing as a primary factor in assessment.

172. The author acknowledges the complexity of policy interactions but opines that a next step on the way to better physical and mental health for all Australians which will have the long-term impact of reducing violence within the community, is to adopt policies built on more overt recognition of the principles of investment in the social determinants of health and through a future generations approach built on a 'health in all policies' strategy.

173. Finally, there is an obligation to ensure adequate compensation of personnel who may be the unfortunate victims of physical assault - or for that matter, psychological harm- which can be just as debilitating. The author takes the unequivocal view that enhanced employer support, extensive counselling and various forms of compensation must be provided as potential forms of redress for victims and their families. Those working in higher risk occupations need to have suitable occupational safeguards that protect the long-term well-being of the individual.

174. Taking that situation further, one might consider that psychological harm that is the result of internal bullying and harassment constitutes a form of assault that can be just as damaging as a physical injury. Chief executives and senior managers need to keep such matters in mind because they create an obligation that cannot be ignored and provide another reason for clear-cut accountability for mental health by management.

⁹¹ Welsh Government, *Well-being of Future Generations (Wales) Act 2015*, <https://bit.ly/2JqSoCh> accessed 03/06/2018

⁹² Owen Richard, *Wales is leading the world with its new public health law*, Croakey, 1 June 2017, <https://bit.ly/2vZPKiW> accessed 03/06/2018

⁹³ *Future Generations Commissioner for Wales*, <https://bit.ly/2tu8RiY> accessed 03/06/2018

⁹⁴ Department of Prime Minister and Cabinet, *Best Practice regulation*, Australian Government, <https://bit.ly/2tBflvl> accessed 22/06/2018

RESPONDING TO THE CHALLENGES

175. Given that one can anticipate the negative cumulative impact of repeated exposure in an emergency services role, employers have a responsibility to respond accordingly. That is, mental health should be considered as a factor within the Occupational Health and Safety regime of employment^{95,96} for which there is no question about accountability - as was determined by WorkSafe Victoria. The impacts may affect not only paramedics but also communications staff, transport officers and other personnel through direct and vicarious trauma.

176. While many individuals appear to cope effectively with workforce conditions, they are still prone to longer term and insidious effects with some beset by mental distress years after they leave a service, pointing to the need for both short and long-term support mechanisms.

177. Some governments have begun to take action in respect of certain sections of the health workforce, and the author welcomes the recent release of the NSW Health Junior Medical Officer (JMO) Wellbeing and Support Plan⁹⁷ in recognition of the toll of mental distress and suicide within the JMO section of the workforce. However, those affected within the health and care professions go well beyond the JMO sector. They include other groups such as paramedics and nurses.

“The measures in this plan are designed to address the major concerns that have been raised by our JMOs. In particular, this plan addresses: safe working hours and fatigue; enabling JMOs to seek help and treatment when needed; providing information about where to seek help; improving the culture in medicine; improving job security; and enhancing transparency in recruitment and employment. These initiatives build on current programs designed to improve the culture in medicine, eliminate bullying, harassment and discrimination, and provide support to JMOs in difficult.”

*Elizabeth Koff
Secretary, NSW Health*

178. The author agrees with the Ministers' message that no single factor will address the complex and intertwining issues that affect the well-being of the health workforce. What is needed is a multi-pronged approach, with initiatives that are evidence-based and address the most serious issues of workload, fatigue and workplace culture. To that end, the present NSW plan has identified ten initiatives⁹⁸ for immediate action, with other initiatives to be pursued in due course.

179. Changing organisational culture is a slow process, and to realise the objectives of a healthy and sustainable working environment will require commitments on the part of NSW Health and its operational units, workforce practitioners at all levels and organisations ranging from the universities to other professional groups together with support mechanisms to identify where action can be taken. It's no easy task, but the need for change is obvious and the measures being

⁹⁵ The Paramedic Observer, *Ambulance Victoria fined for breach of workplace health & safety laws*, Facebook 17 March 2018, <https://bit.ly/2IleJzK> accessed 22/06/2018

⁹⁶ Eburn M, *Drug use by Ambulance Victoria paramedics*, Australian Emergency Law, 12 March 2018. <http://bit.ly/2FQQnNM> accessed 22/06/2018

⁹⁷ NSW Health, *JMO Wellbeing and Support Plan*, NSW Ministry of Health, North Sydney, November 2017. ISBN 978-1-76000-711-9 <https://bit.ly/2jMaB5c> accessed 23/06/2018

⁹⁸ *Ibid* pp 16-18

taken under the present JMO initiative should form only part of the approach to enhancing the culture and operational working arrangements within NSW health.⁹⁹

180. While the toll of mental distress and suicide within the medical profession is horrendous, the serious incidence of PTSD and the high suicide rate are also greater among paramedics than for many other occupations. That demands a similar call for action by all governments.

181. The Victorian Health Minister, in particular, has noted the disturbing rates of PTSD among Victorian paramedics.¹⁰⁰ The Victorian Department of Health and Human Services in recent times has tackled the problem with a proactive strategy¹⁰¹ to promote and drive a consistent, system-wide approach to facilitate cultural change, address bullying and harassment and ensure equity and diversity. Ambulance Victoria is part of this process and has taken significant action.

182. The Australian Centre for Posttraumatic Mental Health (ACPMH) has developed Guidelines that provide recommendations on the best interventions for those exposed to potentially traumatic events as well as those who have developed ASD or PTSI/PTSD. The intended outcome of the Guidelines is increased recognition of ASD and PTSI/PTSD, increased uptake of evidence-based care, and ultimately, better outcomes. The Guidelines note the importance of considering each person's unique circumstances and their overall mental care needs. Crucially, one size does not fit all when it comes to mental health and the appropriate responses for an individual.

183. The Paramedic Association of Canada has prepared a white paper¹⁰² on stress-related mental health issues. This position paper calls for proactive support mechanisms worthy of consideration by the Inquiry in framing its recommendations.

184. Canadian Paramedic Services also have recognised the importance of addressing the issue of paramedic mental health, with paramedic mental health identified as one of the top five priority issues for future standards development work.¹⁰³

185. Across Canada, paramedic services are working to understand how operational stress is affecting paramedics and dispatchers to inform effective strategies that target psychological health in the workplace. They accept there is no all-encompassing off-the-shelf solution for prevention or mitigation of operational stress, but recognise key components that look promising in addressing operational stress and injury.

186. Significantly, the Paramedic Chiefs of Canada¹⁰⁴ acknowledge that responding to operational stress injury and its risks is a shared responsibility involving employees, government departments, unions, workers' health and safety boards, educational institutions and professional associations.

⁹⁹ The Paramedic Observer, *Workforce culture and the need to speak up*, Facebook 12 July 2017. <http://bit.ly/2vvh1JJ> accessed 23/06/2018

¹⁰⁰ The Paramedic Observer, *Continuing the observations on PTSD and related issues*, Facebook 15 May 2015. <https://bit.ly/1H8yCIN> accessed 23/06/2018

¹⁰¹ The Paramedic Observer, *Tackling bullying and harassment in health*, Facebook 27 April 2016. <http://bit.ly/1NQnWBC> accessed 23/06/2018 (See also <http://bit.ly/1QyBF11>)

¹⁰² Paramedic Association of Canada, *Stress-related Mental Health Issues in Paramedics and Their Families*, August 2014, <https://bit.ly/1N8Qr96> accessed 06/06/2018

¹⁰³ Bank, J, *Canadian Paramedic Services Standards Report: A Strategic Planning Report*. Paramedic Standards Steering Panel, Canadian Safety and Security Program, March 2014. <http://bit.ly/1O6sOP2> accessed 13/07/2015

¹⁰⁴ Paramedic Chiefs of Canada, *Operational Stress Injury in Paramedic Services : A Briefing to the Paramedic Chiefs of Canada*, Ad-hoc Committee on Operational Stress Injury , June 27, 2014 <http://bit.ly/1gywiPf> accessed 12/07/2015

187. Nonetheless, the Paramedic Chiefs see paramedic services as bearing an important part of the responsibility for a mentally healthy workplace in fulfilling their role as accountable employers. Their recent review of operational stress injury advocates for a workplace strategy targeting both the individual and the organisational environment or culture - a matter that others have identified – and as noted in the NT Scoping Review.

“The most important aspect within this reform program is promotion of a no-blame culture, empowerment and organisational transparency. It will be achieved through improved internal communications, clear performance measures and improved data and information.”

NT Road Ambulance Scoping Review 2017

188. Further, the Paramedic Chiefs review suggests the adoption of core strategies including comprehension of the injury, developing prevention strategies, creating intervention services and ensuring ready access to treatment.

“This report shows that while the work of paramedic services may be inherently stressful, by investigating the sources of stress in our organizations and amongst our employees, examining the organizational changes we could make, and building services and programs that address stress and psychological wellness, paramedic services can and are demonstrating a caring approach to employee well-being....”

*Operational Stress Injury in Paramedic Services
A Briefing to the Paramedic Chiefs of Canada, June 2014*

189. The new CSA Standard (p 17) is the first of its kind in Canada¹⁰⁵ and reflects the importance of improving the occupational health and safety system by using an effective, coordinated and integrated approach - both for the prevention of psychological health issues and to improve the well-being of paramedic workers.

190. The author agrees with the need for an overarching strategy that will promote staff psychological health, minimise psychological harm due to workplace factors and support protective measures to develop mental health resilience across the workforce. To meet the behavioural support demands in larger services will require the engagement of full-time expert well-being practitioners who are familiar with paramedic practice and who can be called on to attend to the needs of staff outside of a head office and standard clinic hours.

¹⁰⁵ CSA Group, *New CSA Standard Addresses Psychological Health and Safety for the Paramedic Community - A Canadian First*, Toronto April 226, 2018. <https://bit.ly/2r4sHzs> accessed 04/06/2018

191. Identifying the alarming levels of practitioner distress, the ANZCP proposed a jointly sponsored industry sector *Survive and Thrive Resilience Symposium* in 2012. This symposium is now in its third year¹⁰⁶ under the general sponsorship of ANZCP, PA and the regional Council of Ambulance Authorities (CAA). The program is on-going and already is having an impact on practitioner and service attitudes. However, no one or two-day symposium will provide the in-depth support needed at an individual level. Positive long-term action by service entities is required. That action will come with a cost but reap substantial across-the-board benefits.

192. One must be conscious of the difficulties in providing support, especially across a far-flung service and in more isolated settings. Among the various responses that have been found most helpful for those in distress is the use of peer support. Peer engagement can be fostered through early awareness education and training, and implemented through formal organisational arrangements. Peer Support officers are typically nominated employees who take on the role in addition to their full-time operational work. There are several implications, including the restricted time they can devote to the role. Issues that may arise include perceived lack of confidentiality and absence of follow up or delays in responding to a call for help - which creates a problematic situation when it comes to integrity and trust for those who may need urgent assistance following a traumatic event.

193. Peer support activities carry particular stresses, and care needs to be taken to protect all the participants within the support networks. Peers are only part of the solution, and there is a limit to their role and effectiveness which means that additional professional psychological support is generally important. There is [reportedly] often a lack of guidance for peer support officers who should receive both initial and refresher training. The author notes that adequate resources are essential for this training, supervision, evaluation and support to protect the well-being of these nominated peers over time and that first responder agencies would benefit from the adoption of more uniform models for peer support^{107, 108} and crisis management.

194. Peer Support (Accreditation and Certification) Canada¹⁰⁹ has been created to carry on the work started by the Mental Health Commission of Canada in 2010 to transform the mental health system through the integration and promotion of peer support growth, recognition, and accessibility. Among their initiatives is a robust certification process for Peer Supporters and Family Peer Supporters, grounded in the Standards of Practice.

195. Similar training and certification arrangements may have a place in first responder services in Australia to complement existing arrangements. The author also highlights the importance of Peer Support programs for former service personnel as part of a service commitment to the long-term mental health of their employees.

¹⁰⁶ ANZCP, *Survive and Thrive 3 Symposium*, 4 May 2018 <https://bit.ly/2MTvTb3> accessed 11/06/2018

¹⁰⁷ Carleton R, Beshai S, *Peer Support and Crisis-Focused Psychological Intervention Programs in Canadian First Responders: Blue Paper*. Collaborative Centre for Justice and Safety, University of Regina, April 2016. <https://bit.ly/2Kog7GZ> accessed 26/06/2018

¹⁰⁸ Creamer et al, *Guidelines for peer support in high-risk organizations: An international consensus study using the delphi method*, Journal of Traumatic Stress, Wiley Online Library, 20 April 2012. <https://doi.org/10.1002/jts.21685>

¹⁰⁹ Peer Support Canada, <http://www.peersupportcanada.ca/> accessed 06/06/2018

CONSOLIDATING VIEWS AND RECOMMENDATIONS

196. What measures may be adopted to ensure a mentally healthy paramedic and first responder workforce which is exposed to stressful situations on a daily basis? The belief that paramedics must be fearless is a misapprehension and the view that paramedics should *'learn to live with it'* or *'it's just part of the job'* is both uncaring and potentially destructive. It belies human nature and the compassionate healthcare role that paramedics perform in often traumatic circumstances.

197. Paramedics and their colleagues are highly educated people motivated to help others and expected to work independently in difficult situations. As noted in the Joyce Report¹¹⁰ they focus on achieving positive outcomes and when given the opportunity are prepared to contribute wholeheartedly towards improving the services provided for the public.

198. This submission has outlined some underlying factors that have been disclosed in personal interviews in which participants consistently have drawn attention to poor service culture and morale along with ongoing frustration with dated management practices, increasing workloads and other stressors including bullying, harassment and discrimination. This situation obtains despite service providers employing several measures to engender a positive workplace culture. It reflects the deeply embedded nature of much organisational culture.

199. The full extent of cultural deficiencies has not been established across all Australian services, and indeed they appear to vary widely from service to service. Nonetheless, the author believes there is sufficient evidence to warrant significant legislative change and on-going research. A summary of workforce stressors and cultural attributes extrapolated from practitioner inputs, research findings and ambulance service reviews is provided in *Appendix D*.

200. To implement cultural change and develop internal respect and trust, organisations must move beyond the denial stage; learn from the findings of any review; and respond to any identified problems with real change executed in a participative manner. To reduce perceptions of isolation and create 'ownership' of decisions during this process, a high degree of employee involvement is important, especially with professional level staff. This commitment must not be merely lip service but must be genuine involvement manifested through leadership example and by the presence of supervisors and senior managers in the field or area of operations.

201. Good communication builds good relationships, which in turn create a positive workplace atmosphere. Effective internal communications between management and paramedics is thus a must. Communications must incorporate a productive system of feedback to allow staff at all levels to have input and know that they have played a part in implementing change and thereby remove any perceptions of impotence, isolation and futility.

202. What must be appreciated is the extraordinary diversity of operational settings in paramedic and other first responder services throughout Australia, ranging from dense metropolitan to remote area settings; the different sizes of the public agencies and private services; the different sources and levels of funding; and the different stages of development of behavioural support and other organisational arrangements. Just as for individuals, no one set of recommendations fits all, although internal cultural issues figure prominently. What is undeniable is that significant change is required across several areas to reduce the current unacceptable human toll.

¹¹⁰ Government of Western Australia, Department of Health, *St John Ambulance Inquiry: Report to the Minister for Health*, October, 2009 (Joyce Inquiry) <https://bit.ly/2tnjCmg> accessed 15/06/2018

OPTIONS FOR CREATING A RESILIENT WORKFORCE

203. The Inquiry terms of reference deal primarily with the role of Commonwealth, state and territory Governments in addressing the high rates of mental health conditions experienced by first responders. This submission highlights that many of the factors causing mental distress arise from more local operational practices that consistently point to claims of bullying, harassment, nepotism and discrimination which require a local review and change strategy. The principal role of governments in that regard is to ensure adequate funding to enable services to implement suitable responses to change the culture of those services.

204. Only a limited number of matters reflect Commonwealth policies and actions although they are intertwined and far-reaching in scope and generally long-term. These might include potential changes to establish a National Health Care Commission; related changes to health funding agreements and responsibilities; initiatives likely to reduce the long-term prevalence of violence; revised compensation arrangements and uniform legislation for presumptive recognition of OSI; a national Paramedic Services Standard; national accreditation of paramedic service providers; and a national research agenda. Other matters are more jurisdictional and directly service-related.

The recommendations which follow are accompanied by relevant paragraph numbers.

Recommendation 1 (paras. 35-36, 51, 56, 79-80, 84)

That in assessing the nature and underlying causes of mental health conditions experienced by first responders, emergency service workers and volunteers, the Inquiry take note of the narrative content of this submission and in particular, the content of the Lewis Review, the Western Australian IOP review and the Northern Territory Road Ambulance Scoping Review.

Lewis D, *Bullying & Harassment at South East Coast Ambulance NHS Foundation Trust: An Independent Report*, Plymouth University & Longbow Associates Ltd, July 2017. <https://bit.ly/2xuYjUO>
Independent Oversight Panel (2016). *Review of St John Ambulance Health and Wellbeing/Workplace Culture*. August 2016. <https://bit.ly/2MuO5Ym>

Fong N, *NT Road Ambulance Service Scoping Review*, Department of Health, Northern Territory Government, 1 December 2017. <https://bit.ly/2A66cxk>

Recommendation 2 (paras. 166-172)

That the Commonwealth Government commit to a long-term policy position for the overt recognition of the principles of investment in the social determinants of health and through a future-generations approach built on a 'health in all policies' strategy.

Recommendation 3 (paras. 146-148, 178-182)

That the Commonwealth Government establish a National Health Care Commission able to drive health reform through a 'whole of system' approach to health care and funding. Among the reform tasks of the Commission should be a focus on the provision of patient-centred and integrated care with timely access to quality care based on need.

This integrated model should include the recognition of paramedic services as a health service with base funding provided by the Commonwealth. The Commission should have broad responsibilities for the facilitation of health workforce planning including, among other things, the effective mobilisation of a registered paramedic workforce holding prescribing rights to meet currently unfilled community demand for health care.

Recommendation 4 (paras. 129-140)

That the Commonwealth, state and territory governments collaborate in undertaking a review of legislation and compensation models for the rehabilitation and long-term compensation for workplace injuries incurred by public safety personnel with a view to:

- a. harmonising the legislative provisions for work-related injuries across all jurisdictions;
- b. defining psychological distress and harm as a health injury;
- c. providing for the presumptive recognition of PTSI/PTSD as an occupational stress injury;
- d. establishing a non-profit national model of compensation insurance for workplace injury;
- e. providing for compensation for psychological injury to be no less comprehensive than physical injury;
- f. removing perverse incentives that may result in a patient's interests not being given priority in determining the nature and quantum of support for rehabilitation and recovery from an occupational workplace injury; and,
- g. requiring the evaluation of physical and mental injury and the nature and quantum of compensation arrangements through independent panels of healthcare experts.

Recommendation 5 (paras. 132-140)

That the Commonwealth, state and territory governments collaborate in establishing minimum ethical and performance standards to be met by public or private providers of workplace compensation insurance for public safety personnel, and that these standards require inter alia:

- a. the use of standardised definitions across all types of policies in clear, simple language;
- b. commitment to a set of protocols that ensure people with mental health conditions are treated the same as any other consumer making a legitimate claim on their policies;
- c. that compensation evaluators meet minimum standards of knowledge and awareness of mental health conditions and the manifestations of psychological injury and recovery;
- d. the regular updating of definitions in policies relating to medical knowledge based on best practice evidence informed by mental health research;
- e. adoption of agreed standard timeframes for claims processing and limits on the number of medical examinations for a given situation;
- f. provide claimants with written reasons when their applications are rejected, or claims are denied; and,
- g. provide for release on request of statistical and actuarial evidence relied on by an insurer to deny a claim.

Recommendation 6 (paras. 85, 88, 153)

That each Australian jurisdiction including the Commonwealth, appoint a Chief Paramedic Officer as part of the senior policy management structure within the health and social welfare domains. The role may encompass high-level strategic advice to the Minister for Health and the health and emergency service agencies on professional issues in the integration and delivery of paramedic services within the jurisdiction; and include workforce planning in association with other professional groups, educational institutions, professional bodies, and practitioners and service providers in the private sector.

Recommendation 7 (paras. 146-148)

That the Commonwealth, state and territory governments collaborate in establishing a National Action Plan with an emphasis on rigorous and robust research, including a full epidemiology study, to support the mental health of public safety personnel. The relevant Ministers responsible for health, police, emergency and paramedic services should establish a formal platform to share their knowledge and experience in delivering programmes to their career staff and volunteers to address issues of mental health and stress arising from disasters, critical incidents, and on-going exposure as well as effective measures to monitor and develop workforce resiliency.

Recommendation 8 (paras. 105-109, 121, 125, 143-145, 148-160)

That the Commonwealth, state and territory governments collaborate in the development of a National Standard for the delivery of paramedic services and the implementation of a national accreditation and licensing scheme for all public and private paramedic (aka. ambulance) service providers. The accreditation arrangements should provide for an independent National Monitor to perform a regular assessment of regulated services. In addition to operational and clinical matters, the National Standard should incorporate requirements, among other things, for:

- a. compliance with the principles embodied within the National Safety and Quality Health Service (NSQHS) Standards translated into the out-of-hospital environment;
- b. minimum requirements for the provision of student practica that meet the standards for best practice leading to registration as a paramedic;
- c. guidelines on staffing ratios;
- d. guidelines on fatigue management including mandated rest periods;
- e. mandatory provision of professional psychological injury support and behavioural health programs founded on evidence ;
- f. tracking of major incident and individual practitioner exposure to risk; and,
- g. mandatory provision of mental health assessments and psychiatric debriefs accessible by service personnel on a voluntary basis.

Recommendation 9 (paras. 94, 151)

That paramedic service governing Boards forthwith implement a status review, and if not currently in place, take steps to put the long-term psychological well-being of their service personnel at the forefront of organisational planning as part of the service commitment to quality patient care. This review should be a fundamental appraisal of policy and process with the objective of building a true partnership model with staff, professional associations and unions.

Concurrently, services should ensure the training of all officers in psychological first aid, with regular refresher courses to follow. The priority for these mandatory programs should be all senior managers, human resources and well-being support personnel (including peer support staff and chaplains). The content should embrace behavioural standards and mental health awareness including the practical application of the code of conduct, the prevention of bullying and harassment and the management of professional personnel exposed to high occupational risk.

Among the components of the program should be the identification of indicators of mental distress and PTSI/PTSD and the appropriate responses to be taken including referral processes.

Recommendation 10 (paras. 84, 95, 97, 174, Appendix D)

That as part of the proposed service review (*Recommendation 9*), Chief Executives should be tasked with the responsibility for the psychological health of their employed staff and volunteers as reflected in their employment performance agreements. The responsibilities of senior management staff and supervisors likewise should be reviewed and their accountability delineated.

Recommendation 11 (paras. 98-100, 104)

That Occupational Health and Safety legislation and government contractual arrangements mandate the reporting of psychological injuries in the same (or appropriate) manner as physical injury reports for occupational safety.

Recommendation 12 (paras. 44-47, 113)

That paramedic services provide ready access to behavioural health and well-being program for their paid and volunteer staff and their immediate families. These programs should incorporate counselling, crisis intervention assistance, and triage and assessment regarding issues likely to affect the well-being of the individual including alcohol and substance abuse, stress and anxiety, depression, and personal problems that may adversely affect well-being.

The intervention program must, when clinically indicated, refer service personnel or their partners and immediate families to appropriate clinical and specialty care from recognised providers competent to deliver evidence-based treatment consistent with current best practices and standards of behavioural health care developed by acknowledged centres of expertise for treatment of mental health distress such as the Australian Centre for Posttraumatic Mental Health and the Centre for Excellence for the treatment of Post-Traumatic Stress Disorder. The resources and work of other bodies of expertise should also be engaged as needed, including groups such as the Canadian Mental Health Commission, the University of Regina¹¹¹ (Canada) and Dalhousie University (Canada).

Recommendation 13 (paras. 192-195)

That paramedic services provide specific training and support for nominated peer support officers including regular refresher programs and individual mentoring and assessment by professional mental health practitioners. While rapid turnover or rotation is likely to be counterproductive, unbroken peer appointments should be time limited unless all assessment factors indicate continuation in the role is appropriate. Services should also facilitate the certification of peer support officers through programs such as the Peer Support (Accreditation and Certification) Canada program or through a suitable alternative local program.

Recommendation 14 (paras. 14, 23, 62, 151)

Psychological support staff and chaplains (where provided), should be seen to be active in the field with station visits a common activity. Their deployment should follow a well-developed plan that is regularly reviewed and executed. This plan should follow a strategy of visible presence and contact with staff as a normal occurrence and not only when demanded by events. The strategy of engagement should focus on (among other goals) reducing the perceived stigma of distress and fostering self-recognition of the need for support and self-referral.

¹¹¹ Carleton R, Beshai S, *Peer Support and Crisis-Focused Psychological Intervention Programs in Canadian First Responders: Blue Paper*. <https://bit.ly/2Kog7GZ> accessed 26/06/2018

Recommendation 15 (paras. 14, 23, 43, 62, 76-77, 151)

That paramedic services place particular emphasis on providing behavioural support for career staff and volunteers in regional centres and country operations which are perceived to suffer additional stressors and personalisation as a result of isolation, heightened responsibility for training and day to day leadership and management of volunteer staff.

Chaplaincy services, peer support officers and professional well-being practitioners undertake important, but different and complementary roles. Services should fund adequate chaplaincy services where indicated, and this may be prudent in rural and remote areas.

Recommendation 16 (paras. 42, 94, 121-128, 192-195)

That first responder services actively assist the development of peer groups for former personnel to enable long-term association and potential follow-up in the event of late development psychological distress. These groups may be engaged for their contributions in a variety of ways including mentoring, induction, peer support and volunteer activities.

Recommendation 17 (paras. 83, 121-122, 124, 128)

That structured awareness programs on mental health and addiction be included within initial degree qualification programs for paramedics as part of their education and professional development. These programs should cater not only for awareness of patient issues but also provide insights into self-awareness and mental health designed to foster self-assessment of mental status and capability.

Recommendation 18 (paras.121-122)

That the accreditation of paramedic education programs include an assessment of the adequacy of content associated with mental health and addiction.

Recommendation 19 (paras. 55, 66, 69, 81-82, 84, 89-90, 203)

That paramedic services develop clear career paths for paramedics and ensure clinical and operational pathways for progression that allow rotation into meaningful roles when required for physical and mental health reasons and to ensure appropriate succession planning and promotion on merit.

Recommendation 20 (paras. 94-96, Appendix D)

That where senior staff are engaged but are not previously experienced in paramedic services (or equivalent) at the time of appointment, service induction programs should include an unbroken period of in-field relevant exposure to frontline services in metropolitan and more remote areas across matching full-shift (day/night) operations.

Recommendation 21 (paras. 16, 60-62, 84, 89, 103)

That all volunteers be provided with a structured induction program that includes an introduction to the service code of conduct and operational structure; an introduction to mental health (literacy) and self awareness sufficient to self-appraise mental fitness and capacity; and information on the support mechanisms available within the service that can be accessed in the event of identified distress. This program should be no less comprehensive than the Mental Health First Aid 12-hour courses that educate individuals on mental health, prevalence, stigma, illness, support and self-care.

Recommendation 22 (paras. 17, 36, Appendix D)

That each paramedic service develop a confidential database able to record staff activity at the scene of a prolonged disaster or other major events that can ensure effective fatigue management and monitor potential over-exposure to trauma. This monitoring is especially important where a deployment period exceeds a regular shift or personnel are deployed to a significant disaster, and family contact is important.

The data collection capability might also include the cumulative exposure of staff and the number of traumatic events they have attended over a particular period. This monitoring process may also form part of an exit interview and relocation strategy for both career staff and volunteers

Recommendation 23 (paras. 17, 36, 181-190)

That a comprehensive and confidential monitoring regime be developed across all first responder services, including paramedic services, to capture the incidence of behavioural distress (above a defined threshold) and suicides that might reasonably be attributed to occupational stress exposure as part of a national approach to developing effective data for evidence-based decisions on mental health care.

Recommendation 24 (paras.97-104)

That each jurisdictional government facilitate the establishment of a joint Emergency Services and Paramedic Services collaborative body to aggregate and support appropriately qualified and independent clinical and specialty care resources, both for professional psychological care and for peer support. The body might work with other established centres of excellence such as the Centre for Excellence¹¹² for the treatment of Post-Traumatic Stress Disorder and the Australian Centre for Posttraumatic Mental Health¹¹³ in developing appropriate models of prevention and care which may then be adapted by individual services to suit their operational circumstances.

The use of retired service staff as mentors or peer supporters has proven valuable, and services should also explore the usefulness of using retired staff, either through direct employment or a suitable non-government organisation (*Recommendation 16*).

Recommendation 25 (paras.17, 19, 38, 50, 159-160, 165, Appendix D)

That first responder services continue to address the issues of physical and mental injury from preventable handling issues and exposure to external environmental risk factors including traumatic incidents and heightened fears of abuse and assault. The measures adopted and their evaluated outcomes should be publicised and shared through the national network of agencies.

Recommendation 26 (paras. 143, Appendix D)

That the design of paramedic service facilities (including relevant call centres) incorporate discrete 'safe' or 'quiet' spaces to enable staff to seek relief in the event of a need arising from highly stressful events or an accumulation of stress. This space should be included as a dedicated space allocation in all future stations. Existing stations should be retrofitted or suitable space located in a contiguous building.

¹¹² <http://transforminghealth.sa.gov.au/expert-panel-starts-planning-for-new-ptsd-centre-for-excellence/> accessed 14/07/2017

¹¹³ <http://psych.unimelb.edu.au/research/partner/university-melbourne-australian-centre-posttraumatic-mental-health> accessed 14/07/2015

Recommendation 27 (paras.17, 19, 38, 50, 158-159, 164, Appendix D)

That paramedic services continue to address the issues of physical and mental injury from direct work-related preventable handling issues and exposure to external environmental risk factors including traumatic incidents and heightened fears of abuse and assault. The prevention and protective measures adopted and their evaluated outcomes should be publicised and shared through the national network of agencies.

Recommendation 28 (paras. 19, 164, Appendix D)

That paramedic services continue their media promotions designed to stress the importance of community support for first responders and the unacceptable nature of unwarranted interference, abuse or assault. The media outcomes should be shared nationally through the appropriate release of copyright and adaption to local conditions.

The author further opines that these preventive messages may be leveraged effectively by combining them judiciously with a positive approach to community and bystander engagement through initiatives such as GoodSam and bystander CPR and thereby reaping an overall better outcome.

Recommendation 29 (paras. 110-114)

That all paramedic service providers undertake an operational audit to consider the issues raised in the Operation Tone report and its recommendations to assess whether similar vulnerabilities could exist in their control and management of drugs, and if found, to take any necessary corrective and control action.

ABBREVIATIONS

The following abbreviations are used in this submission.

ANZCP	Australian and New Zealand College of Paramedicine
ASD	Acute Stress Disorder
CPR	Cardipulmonary Resuscitation
CQC	Care Quality Commission (UK)
EMS	Emergency Medical Services
HIA	Health Impact Assessment
IOP	Independent Oversight Panel Review (WA)
JMO	Junior Medical Officer
NHS	National Health Service (UK)
NSQHS	National Safety and Quality Health Service
NT	Northern Territory
OSI	Occupational Stress Injury
PA	Paramedics Australasia
PSP	Public Safety Personnel
PTSI/PTSD	PTSI – Post Traumatic Stress Injury / Post Traumatic Stress Disorder
RoGS	Report on Government Services
SJA	St John Ambulance Service
UK	United Kingdom
US	United States of America
WA	Western Australia

APPENDIX A – CONSULTATION PURPOSE AND OBJECTIVES

Senate Inquiry into Mental Health – Terms of Reference

The Terms of Reference set out the purpose of the Inquiry which are described below.

The role of Commonwealth, state and territory Governments in addressing the high rates of mental health conditions experienced by first responders, emergency service workers and volunteers, with particular reference to:

- a. the nature and underlying causes of mental health conditions experienced by first responders, emergency service workers and volunteers;
- b. research identifying linkages between first responder and emergency service occupations, and the incidence of mental health conditions;
- c. management of mental health conditions in first responder and emergency services organisations, factors that may impede adequate management of mental health within the workplace and opportunities for improvement, including:
 - i. reporting of mental health conditions,
 - ii. specialised occupational mental health support and treatment services,
 - iii. workers' compensation,
 - iv. workplace culture and management practices,
 - v. occupational function and return-to-work arrangements,
 - vi. collaboration between first responder and emergency services organisations,
 - vii. post-retirement mental health support services, and
 - viii. resource allocation; and
- d. any other related matters.

APPENDIX B – AUSTRALIAN AMBULANCE SERVICE MODELS

(Source – Table 8 – NT Road Ambulance Review – December 2017)

Table 8 – Summary Australian Ambulance Service Models

	Queensland Ambulance Service	Ambulance Victoria	Ambulance Tasmania	NSW Ambulance	ACT Ambulance Service	SA Ambulance Service	SJAWA	SJAANT
Government (DoH)	Yes	Yes	Yes	Yes	-	Yes	-	-
Government – Other Department	-	-	-	-	Emergency Services	-	-	-
Non-Government service	-	-	-	-	-	-	Yes (excl Kimberley Region).	Yes
Jurisdictional wide service	Yes	Yes	Yes	Yes	ACT + SE NSW	Yes	Yes	Yes
Regional operational structure	Yes	Yes	Yes	Yes	No	No	Yes (excl Kimberley Region)	Yes
Emergency medical response and pre-hospital care	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Non-Emergency Patient Transport	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Inter-facility ambulance transport	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Na
Aero-medical retrieval - Fixed Wing	Coord	Yes	Yes	Yes	Yes	RFDS	RFDS	RFDS/ CareFlight
Aero-medical retrieval/ rescue – Rotary (Helicopter)	Coord	Yes	Yes	Yes	Yes	Yes	No (DEFES Service – supported by SJAAWA Paramedics)	No (Provided by Care Flight only in Top End)

APPENDIX B – AUSTRALIAN AMBULANCE SERVICE MODELS (Continued)

	Queensland Ambulance Service	Ambulance Victoria	Ambulance Tasmania	NSW Ambulance	ACT Ambulance Service	SA Ambulance Service	SJAWA	SJAANT
Casualty room services	Yes	No	No	No	No	No	Urgent Care Centres	No
Emergency call taking, triage, dispatch and coordination	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Coordination of rotary & fixed-wing aero-medical responses	Yes	Yes	Yes	Yes	Rotary only	Yes	Yes	No
State-wide communications centre	No	na	Yes	na	Yes	Yes	Yes	No
Joint emergency communications & coordination centre	Na	na	No	na	Yes	Yes – standby incident room	No	Partial
Planning and coordination of major incidents and disasters	Yes	Yes – health only	Yes - all	Yes: health only	Yes	Yes – health only	Yes (as above)	Yes
First Aid training, community education, first aid at public events	Yes	na	Yes	Yes	na	No	Yes	Yes
Volunteers supplementing local ambulance services	Yes/ rural and remote	Yes/rural	Yes/ not in major cities	Yes	na	Yes	Yes	Yes: remote only
Volunteer only stations/ crews	Yes	No	Yes	Yes	No	Yes	Yes	No
Volunteer run first aid, fund-raising and community services	Na	na	Partial	Partial	na	No	Yes	Yes
Commercial activities	Yes	na	No	No	No	No	Yes	Yes

APPENDIX C - THE IMPLICATIONS OF MORALE FOR PARAMEDIC SERVICES

A healthy workplace environment will provide a mixture of improved operational performance, less damage to personnel through impairment or tragic losses through death, with consequential better service and cost savings for the community.

Among the suggested implications and costs of poor morale are:

Decreased productivity: poor morale is likely to reduce worker engagement and thus stifle innovation and performance as apathy develops that negatively impacts the work ethic of individuals. Since the major paramedic service like SJA and WFA provide a public health service, the role of staff engagement applies somewhat differently from that of other industries. The ultimate goal should not be profit but to render cost-effective and best practice service, for which a positive work environment is vital. The complex and highly stressed nature of paramedic practice is edgework (p 22) that requires a tailored approach to nurture morale.

Increased illness/absenteeism: Studies have shown that stress, over and above normal healthy levels, has significant detrimental side effects on an individual's overall health and well-being, including potential propagation into mental health issues (see earlier discussion).

Shift problems: Paramedics typically operate across a variety of scheduled shifts and rosters depending on the location. Smooth changes and team collaboration are critical for colleagues. Tardiness, missed shifts and other changeover issues (e.g. cleanliness, preparation, stocking) due to poor morale and apathy can magnify irritations that become major stressors and issues for internal disputation.

Increased grievances: Inconsistent managerial practices and unhappy employees tend to create friction within the workplace which can lead to errors in judgment and intemperate actions. Instead of resolving matters amicably with a simple phone call or conversation, they may lead to unnecessary complaints. Complaints and grievances require significant time and resources to be properly managed and processed which adds stress and takes time away from the normal operating duties of all parties, contributing to the frustrations generally felt across all staff.

Interpersonal Conflict: Poor morale goes hand in hand with internal personnel disputes. Disagreements may occur in the best of circumstances, and if they grow to become disputes, then good management dictates effective resolution. How those disputes are managed with investigative rigour, due process, natural justice and in a fair and objective manner is critical to long-term morale and corporate culture. The advent of paramedic registration should help to clarify the professional status of paramedics and thereby improve morale by separating disciplinary matters from issues of professional fitness to practice.

Increased injury levels: Unhappy employees are less likely to have regard for their safety and that of others (including patients). While maintaining health and safety is a normal organisational objective, work-related injuries do happen. These injuries may cost thousands of dollars and reach far beyond the actual injury itself through 'knock-on' effects.

However, it is not just the dollar value attached; it is the employee¹¹⁴ who ultimately suffers. Paramedics have a physically demanding job, with lifting being a frequent activity and often in difficult settings. Although many services are improving training and equipment is being upgraded and replaced, which can further mitigate potential injuries, happy and engaged employees will tend to take greater care not only in how they lift but also across all aspects of their duties.

Staff turnover/retention issues: Unhappy staff may seek relocation or leave for alternative employment. These losses are very significant in some jurisdictions, and anecdotal evidence suggests some loss of staff because of mental distress or poor morale.

The costs of unplanned losses include the need for recruitment and induction of replacement staff, and if the departing staff hold particular roles or training responsibilities such as community paramedics, there is not only a loss of expertise but also highly valuable networks and volunteer relationships.

Program improvement costs: Poor morale demands remedial action, and that means committing resources to implement a tailored program aimed at overcoming the situation. No estimate of this cost can be made without a closer study of particular situations.

¹¹⁴ Maguire, O'Meara, Brightwell, O'Neill, Fitzgerald, *Occupational injury risk among Australian paramedics: an analysis of national data*, Med J Aust 2014; 200 (8): 477-480 <http://bit.ly/1OdhJfa> accessed 14/04/2018

APPENDIX D – INDICATIVE SUMMARY OF NOMINATED WORKPLACE STRESSORS

A summary of these workforce stressors and cultural attributes extrapolated from practitioner inputs, research findings and ambulance service reviews is provided below:

- Increasing call volumes and resulting workloads not matched by resource growth;
- Increased expectations, clinically and operationally; and inconsistencies associated with changes in the various scopes of practice;
- Inadequate workplace health and well-being programs;
- Promotion of staff with limited operational experience and poor communication skills, and related perceptions of favouritism and conflict of interest;
- Restructuring of work patterns by fiat with limited input from staff, and poor communication of objectives and perceived outcomes;
- Lack of empathy and limited or little follow-up of personnel through health and well-being processes (where they exist) intended to provide staff support;
- A perceived lack of support from management and inadequate peer support, resulting in a disconnect between management and operational staff; lack of credibility and trust;
- Inability to deal effectively with meal break and end-of-shift relief issues;
- Lack of time or inability to have a safe space in which to reflect and 'decompress';
- The inability of paramedics to forward ideas in the workplace and be taken seriously;
- Performance management processes that involved micro-management and destructive nit-picking issues;
- Management staff unwilling and unprepared to be accountable for decision making;
- Lack of appropriate progression; lack of independent complaint processes and a lack of communication regarding investigation procedures; with the perception that the paramedic is guilty until proven innocent,
- Lack of transparency in handling complaints and grievance issues; perceived conflicts of interest;
- Bullying and harassment through various mechanisms including statements by senior management that embarrass and denigrate staff;
- Poor treatment of impaired and injured staff (physically and mentally); limited follow-up; abandonment; lack of long-term support;
- Arduous evaluation and compensation processes in dealing with mental distress;
- Hospital ramping and delay issues that accentuate general stress;
- Concern at (preventable) physical injury occasioning the loss of position as a practitioner;
- Lack of quiet spaces and 'downtime' to decompress; and,
- External environmental risk factors including regular exposure to traumatic incidents and heightened fears of abuse and assault in responding to calls for assistance.