WHEN HELPING HURTS: PTSD IN FIRST RESPONDERS

Report following a high-level roundtable

Paul Barratt, Lyn Stephens and Mick Palmer

The high rates of mental health conditions experienced by first responders, emergency service workers and volunteers
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PTSD IN FIRST RESPONDERS report

About Australia21

Australia21 is an independent, not for profit think tank, which promotes fair, sustainable and inclusive public policy through evidence-based research. Inspired by the Canadian Institute for Advanced Research (CIFAR), Australia21 was founded in 2001 to develop new frameworks for understanding complex real-world problems that are important to Australia's future. Past projects have covered a wide range of areas including inequality, illegal drug policy, refugee policy, assisted dying and the algal industry.

Australia21 is not politically aligned and encourages the contribution of diverse views and multidisciplinary approaches to its investigations. This enables it to go beyond politically aligned research and populist consensus to look at the evidence and experience of what works without bias, with the sole interest of promoting the common good and what is best for Australia now and in the future.

About FearLess Outreach

The vision of FearLess Outreach is to create a coordinated network of outreach and support services with the aim of helping those with lived experience of PTSD and their families regain control over their daily lives. A community-owned and community-operated Post-Traumatic Stress management protocol for these services is currently under development. Members come from all walks of life including those living with PTSD and their families, and those who want to contribute to making the lives of people living with post-traumatic stress more enjoyable and fulfilling. The work of FearLess Outreach complements the activities of other community-based organisations and government agencies that provide services to people with post-traumatic stress.

Fearless Outreach has a growing national presence throughout Australia and New Zealand, and aims to have local representation in areas where there is a concentration of people who live with post-traumatic stress. In due course, it is hoped that FearLess will be able to sponsor world-class collaborative research by Australian universities and research centres into the causes and treatment of PTSD.

Our sponsors

We are grateful for the support of our sponsors for this project — the Australian Federal Police, Victoria Police and the Northern Territory Police, Fire & Emergency Services.

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MORE SECTORS OF SOCIETY THAN FIRST THOUGHT MAY BE AFFECTED BY PTSD —

beyond the military to first responders, to journalists who report trauma and may also be exposed to threat, to people who have lived with domestic violence, to refugees in indefinite detention, to people from indigenous communities dealing with historical and current trauma, to prison populations and victims of violent crime.

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EXECUTIVE SUMMARY

PTSD IS A DEBILITATING AND OFTEN CHRONIC MENTAL HEALTH CONDITION ASSOCIATED WITH HIGH LEVELS OF DISTRESS

Because the trauma associated with the event often shatters a person's basic assumptions held about the world, other people and themselves, it is in a sense personally defined. The same event may result in little or no adverse reaction in some people yet precipitate debilitating post-traumatic mental health issues in others.

This is the report of a day-long roundtable which was held at Australian Federal Police Headquarters in Canberra in May 2017, under the chairmanship of former AFP Commissioner Mick Palmer, to explore better ways of preventing the debilitating mental consequences of traumatic stress and improving mental health outcomes for front-line first responder personnel. The approximately 45 participants included representatives from first responder organisations (operational and command-level personnel), employee associations, support groups, academics, and health care professionals from most States and the two Territories. Some key players from the Australian Defence Force and the Department of Defence were also invited to share their experience in dealing with PTSD. Some of the participants were people who had experienced or were still recovering from PTSD.

The report is considerably enriched by the generous sharing of lived experience by many of the participants. This material was used throughout but particularly in Chapters 4–7.

This roundtable followed the publication by Australia21 of a volume of short essays *Trauma-related stress in Australia: Essays by leading Australian thinkers and researchers*, written by psychiatrists and psychologists, people who have lived with the effects of trauma-related stress and their families, administrators of frontline organisations including police and Defence personnel, and people who have observed the havoc it produces in disadvantaged communities. The purpose of the essays was to stimulate broad community understanding of the relationship between trauma and mental health and the need for better structured mental health systems with improved prevention and treatment options.

First responders are the men and women who deliver the initial response to any kind of emergency situation, whether it be the result of a natural disaster, an accident, or a deliberate human act causing or threatening to cause injury or loss of life. They include police, fire, ambulance, paramedics, rescue and other emergency services personnel.

It is in the nature of these emergencies that, while they can and must be prepared for by means of training and the acquisition of appropriate equipment, they do not take place at a time, or on a scale, of the relevant organisation's choosing. Whilst in some situations, such as issues of social disorder, floods and cyclones, it is possible to predict and prepare for the likelihood of an event, it is rarely possible to predict the degree of severity or damage, and in many cases incidents (such as road accidents, house fires and homicides) arise randomly and unpredictably. The challenge, and the public expectation, is that first responder agencies have a stand-by capability ready to respond to any emergency that arises in the twenty-four hours of every day of the year.

The risk of post-traumatic stress is inherent in the work that first responders do. They spend a great deal of their professional lives dealing with people in urgent need, who are usually highly distressed and often injured, and they do this in situations where their own safety may also be at risk. They are at high risk of developing serious stress arising from the traumatic events in which they are involved, and this may lead to the condition that we now know as post-traumatic stress disorder (PTSD).

First recognised as a syndrome by the mental health professions in the 1980s, PTSD is a debilitating and often chronic mental health condition associated with high levels of distress. It is usually triggered by exposure to traumatic situations where an individual may be placed in a life or death situation that can also challenge their emotional resources, beliefs and values. A distinction is sometimes made between Type I trauma which describes a single event, such as an assault, accident or natural disaster, and Type II trauma which describes prolonged and repeated trauma, such as ongoing domestic violence, war or severe political repression.

The diagnostic system now also recognises traumatic stress conditions that can arise from indirect or vicarious exposure, e.g., to online child exploitation, and details of terrorist acts and other atrocities. The staff member is not under any direct personal threat but repeatedly experiences details of such exposures. Examples include a police officer who spends each day taking witness statements from victims of child abuse, forensic staff identifying bodies in the aftermath of natural disasters and war zones and child protection workers repeatedly exposed to highly dysfunctional family circumstances.

Because the trauma associated with the event often shatters a person's basic assumptions held about the world, other people and themselves, it is in a sense personally defined. The same event may result in little or no adverse reaction in some people yet precipitate debilitating post-traumatic mental health issues in others. In some cases a person may exhibit no adverse reaction through a range of stressful events and then suffer a significant mental health reaction to a single similar event — even a relatively minor one — as a consequence of the cumulative impacts of such events The powerful emotions generated by such events can become associated with a range of reminders or triggers through a process of conditioning, so for some people the symptoms persist and they may be unable to move on from the event. Eventually they may develop PTSD, with ongoing disturbing thoughts, feelings or dreams related to the event, mental or physical distress in response to trauma-related cues, and alterations in how they think and feel.

Knowledge about the treatment of PTSD is now strongly evidence-based and well delineated. For example, Phoenix Australia has produced *Australian guidelines for the treatment of acute stress disorder and post-traumatic stress disorder* endorsed by the National Health and Medical Research Council, and the Black Dog Institute has published *Expert guidelines: The diagnosis and treatment of post-traumatic stress disorder in emergency service workers*. However, a recent audit of clinical practice in one State found that the skills needed to provide state-of-the-art psychological therapy are not always available to those who are managing the patient. Less than 50% of treatments reviewed in that State were consistent with PTSD clinical guidelines.

There is also a gap in getting to the right treatment for the right illness. The first contact is often with GPs, who frequently lack the skills or expertise to appropriately diagnose PTSD, or may not be across best practice in this area. This can flow on to the referrals for treatment.

Against that background, there is recognition that not all victims of PTSD are helped by currently available therapies, even when provided by therapists using best practice. Outcomes are better for women, non-veterans and people with single rather than multiple/complex exposure. In general terms, about one third of people with PTSD recover with treatment, one third gain significant benefit but are still symptomatic, and one third gain little benefit. The challenge is to improve these ratios.

The roundtable was structured around the following four questions:

1. What are the particular triggers that create stress in otherwise resilient and well-trained first responders? How does the stress manifest itself? What skills or understandings would assist first responders to better identify and effectively support and manage trauma-related stress?

2. How are these issues currently being managed?

3. How could these issues be better managed?

4. What needs to be done now in Australia to better prepare first responders for the issue and to better manage the problem across primary responder professions?

A review of the Roundtable discussion identified a number of knowledge gaps:

- How best to manage exposure to minimise the risk of people becoming injured in the first place
- How best to advise people who are troubled by stress in the immediate aftermath of a trauma exposure
- How to predict why some people go on to develop PTSD and others do not
- How more effectively to prevent or minimise trauma-related stress in the workplace
- How to broaden understanding about the epidemiology of PTSD among first responders and the workplace issues that can mitigate or worsen its effects.

As already noted, not all victims of PTSD are helped by currently available therapies, even when provided by therapists using best practice. While one third recover with treatment and one third gain significant benefit but are still symptomatic, the final third gain little benefit.

Our review also identified a range of challenges for consideration by first responder organisations:

- Managing exposure is and will remain an enormous challenge, especially in the small stations in regional and remote areas served by first responder organisations. These small stations do not have the resources to manage staff rotation, and they do not have the same access to expert treatment that stations in metropolitan areas have.
- There is a profound reluctance among operational staff to seek help, because they assume this will be disastrous for their careers. Normalising the mental health consequences of dealing with confronting situations, so they can be talked about openly, is a key challenge.
- There are management issues associated with training operational managers on the known impacts of trauma-related stress and approaches to managing its effects; how to deal with impacted staff, whether that be in the context of their first seeking help or return to work, and with the return to work itself.
- There are resourcing challenges for senior managers in bidding for the resources required to enable them to manage exposure by providing the resources which will enable their operational units to provide the responses expected by the public they serve in a manner which is as safe as possible for their personnel.

Finally, there are some important framework issues to be addressed by senior management:

- Developing an organisational culture that genuinely recognises and embraces that "helping hurts" and that stress-related trauma is simply a reflection of the work and demands that are the first responder workplace.
- Arrangements to minimise the impact of inquiries or legal proceedings consequent upon an incident on the individual(s) involved, and of media intrusions. While the processes are afoot, the individual(s) concerned should be shielded by their organisations from avoidable pressures.
- Ensuring that the compensation processes for personnel affected by PTSD are not such as to exacerbate the mental stress of the individuals concerned. This might require a legislated presumption that, if a worker is exposed to certain types of traumatic events and is diagnosed with PTSD, it is caused by the worker's employment, unless the contrary is proven.
- Development of a more structured mechanism for sharing information on good practice across first responder jurisdictions.
- Development of a national system for gathering standardised epidemiological data about the incidence of PTSD in first responder organisations.
- Development of a national policy framework for dealing with PTSD in first responders.
- Development at the national level of appropriate education and training materials.
- Campaigning to strengthen the national research effort.
- Putting the matter on the national political agenda.

These are the issues that we unpack, discuss and make findings and recommendations about in this report. We have a long list of recommendations. While all are important, implementation will take time, and they will need to be prioritised.

In our view the key priorities are:

1. Within the broader context of growing community understanding that mental illness is not in any sense, a marker of a genetically inferior being but a response to life challenges that we all face, normalising attitudes to post-traumatic stress in first responder organisations and clarifying what happens when people seek help.

2. Normalising attitudes to post-traumatic stress in first responder organisations and clarifying what happens when people seek help.

3. Developing WH&S guidelines which outline the preferred or expected limits of exposure during normal operations.

4. Ensuring, as far as is reasonably possible, that impacted personnel receive, in a timely way, the right treatment for the right illness.

5. Implementing a case-managed return to work process for affected personnel, without financial penalty.

6. Supporting impacted personnel in dealing with compensation claims.

7. Introduction of the major policy changes outlined in Recommendation 30, including the introduction of a Canadian-style presumption in workers' compensation legislation.

8. Introduction of people management and mental wellbeing training for first responder managers.

9. Establishment of collaborative arrangements to build on work already done, including in Defence, to share good practice across jurisdictions and to advocate for improved treatment and policy options in the interests of all first responders.

INTRODUCTION

IT WAS DECIDED TO FOCUS THIS STAGE OF THE PROJECT ON FIRST RESPONDERS, DRAWING HEAVILY ON LIVED EXPERIENCE

As a group, first responders have high value to the community and they suffer from high rates of PTSD due to the potentially traumatic environment in which they work. This means the risk of PTSD must be mitigated and managed, because it cannot be avoided.

BACKGROUND

How this PTSD project came into being

Like many initiatives this project, a partnership between Australia21 and FearLess Outreach, grew out of relationships and shared concerns. The heads of Australia21 and FearLess Outreach, Paul Barratt and Chris Barrie, were both former senior leaders in the Department of Defence — Paul as Secretary of the Department and Chris as Chief of the Defence Force. These roles gave them first-hand experience of the impact of PTSD on the health and welfare of serving personnel and their families and on organisational capability. Add Mick Palmer, former Commissioner of the Australian Federal Police — an organisation where potentially traumatic events are everyday occurrences and too many people become injured by PTSD — and you have a powerful trio committed to building better understanding of and a stronger and better response to this condition at the level of the individual affected, their organisations, the community, policy makers and the political sphere.

The project began with a volume of short essays *Trauma-related stress in Australia: Essays by leading Australian thinkers and researchers*, written by psychiatrists and psychologists, people who have lived with the effects of trauma-related stress and their families, administrators of frontline organisations including police and Defence personnel, and people who have observed the havoc it produces in disadvantaged communities. The purpose of the essays was to stimulate broad community understanding of the relationship between trauma and mental health and the need for better structured mental health systems with improved prevention and treatment options.

After consultations with the project Advisory Group, it was decided to focus the next stage of the project on first responders, drawing heavily on lived experience, to explore better ways of preventing the debilitating mental consequences of traumatic stress and improving mental health outcomes. It was decided to hold a one-day Roundtable with representatives from first responder organisations, employee associations, support groups, academics, and health care professionals from most States and the two Territories. Some key players from the Australian Defence Force and the Department of Defence were also invited to share their experience in dealing with PTSD.

Why start with first responders?

The demographics of PTSD are broad and growing and include many more sectors of society than the Defence force and first responder organisations, such as journalists who report trauma and may also be exposed to threat, people who have lived with domestic violence, refugees in indefinite detention, people from indigenous communities dealing with historical and current trauma, prison populations and victims of violent crime.

While symptoms are similar, they can result from many different contexts, which require different approaches to aid recovery. The topic is far reaching and, if tackled in its entirety, overwhelming. For this reason, it was decided to focus initially on PTSD in the first responder community, however we hope to do reports on other sectors affected by PTSD as funds become available.

As a group, first responders have high value to the community and they suffer from high rates of PTSD[1] due to the potentially traumatic environment in which they work. This means the risk of PTSD must be mitigated and managed, because it cannot be avoided. As well, a number of leaders in the first responder sector have been calling for new approaches to the problem, so there is a willingness to support new ways of dealing with the issue. We also felt there were enough organisational similarities between the Defence environment and the command and control environment of first responders to be able to draw directly on the extensive Defence experience for the benefit of first responders.

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[1] It is difficult to get precise figures because the data in available studies is not always comparable, but some put the rate of PTSD among first responders as high as 20%.

About the Roundtable

Around 45 people attended the one-day Roundtable, representing most states and territories, a range of organisations and a range of occupational roles, including from the Defence community. Several people had personal experience of PTSD. The conversation took place in May 2017 and was structured around the following four questions:

1. What are the particular triggers that create stress in otherwise resilient and well-trained first responders? How does the stress manifest itself? What skills or understandings would assist first responders to better identify and effectively support and manage trauma-related stress?

2. How are these issues currently being managed?

3. How could these issues be better managed?

4. What needs to be done now in Australia to better prepare first responders for the issue and to better manage the problem across primary responder professions?

5. Prior to the Roundtable all participants were asked to provide a brief outline of their personal background and to prepare a short response to the question: 'What is your experience of post-traumatic stress personally and in members of your professional group? How can prevention and management of the impact on first responders be improved?' Responses were collated and made available to all participants before the Roundtable, and in some cases used in the report.

At the Roundtable, participants were encouraged to share their lived experience under the Chatham House Rule and they did so with remarkable openness. A transcript of the conversation was prepared. A draft report was compiled from this material and subsequently provided information, and sent to all participants for feedback and further comment. The outcome is this report. While it draws heavily on input from Roundtable participants it is published under the sole auspices of Autralia21 and FearLess Outreach. Our hope is that the information and stories it contains, together with our findings and recommendations, will trigger the changes in policy, practice and resourcing that our first responders desperately need if they are to continue to provide the essential services we expect of them in the future.

THE RISK OF POST-TRAUMATIC STRESS IS INHERENT IN THE WORK THAT FIRST RESPONDERS DO

It is in the nature of the emergencies to which they respond that they do not take place at a time, or on a scale, of the relevant organisation's choosing. The challenge, and the public expectation, is that first responder agencies have a standby capability ready to respond to any emergency that arises in the twenty-four hours of every day of the year.

CHAPTER 1:
DEFINING THE PROBLEM

The risk of post-traumatic stress is inherent in the work that first responders do. First responders are the men and women who deliver the initial response to any kind of emergency situation, whether it be the result of a natural disaster, an accident, or a deliberate human act causing or threatening to cause injury or loss of life. They include police, fire, ambulance, paramedics, rescue and other emergency services personnel.

It is in the nature of these emergencies that, while they can and must be prepared for by means of training and the acquisition of appropriate equipment, they do not take place at a time, or on a scale, of the relevant organisation's choosing. Whilst in some situations, such as issues of social disorder, floods and cyclones, it is possible to predict and prepare for the likelihood of an event, it is rarely possible to predict the degree of severity or damage, and in many cases incidents (such as road accidents, house fires and homicides) arise randomly and unpredictably. The challenge, and the public expectation, is that first responder agencies have a stand-by capability ready to respond to any emergency that arises in the twenty-four hours of every day of the year.

For this to occur, resources must be geographically dispersed so that an emergency response can be mounted within a reasonable time in every part of every jurisdiction across the continent. How 'a reasonable time' is defined can mean the difference between life and death, and can have a dramatic impact on the scale of property damage. In some cases the reality — either because of the tyranny of distance or the scale or nature of the disaster or incident — is that the best response possible may not meet the public perception of 'reasonable time' or indeed the lifesaving requirements of 'reasonable time' (e.g. a mine collapse or ship capsize). This reality needs to be understood.

Incidents that require an emergency response almost inevitably involve death and/or injury and/or loss of property such as houses and contents, livestock, or other treasured possessions. So there is usually a compelling need to respond — and to make critical decisions — quickly. It is this urgency along with the threatening nature of the event that characterises what first responders do. It is a corollary of these circumstances that first responders spend a great deal of their professional lives dealing with people in urgent need, who are usually highly distressed and often injured, and they do this in situations where their own safety may also be at risk.

Managing the expectations of this crisis environment and the health and wellbeing of the personnel who commit themselves to this work in order to look after the rest of us has many of the characteristics of a wicked problem. For instance, there are important trade-offs between the size and distribution of first-responder stations that require consideration: the maximum transit time — how long it would take the first responders to arrive at a point on the outer limits of the area for which they are responsible; the maximum scale of an incident each first responder post can handle without reinforcement; critically, the capacity of the post to handle concurrency — two or more incidents at the same time; and the capacity of each post to give its personnel reasonable stand-down time.

While a smaller number of larger stations would be able to handle incidents of greater scale and would have a better capacity to handle concurrency, in each Australian jurisdiction except perhaps the ACT there are areas in which effective assistance could not be rendered within an acceptable time.

Decisions on the optimum distribution of resources for the most effective response capability to the population as a whole is complex enough, but managing the wellbeing of the first responder workforce entails another set of resource allocation and management decisions. These include how to staff first responder organisations to accommodate some recovery time from the inevitable stresses of their role; how to prepare first responders for the psychological risks of the job without undermining the motivation and spirit that attracted them to the work in the first place; how best to provide in-service psychological counselling and training to maximise personal resilience while also enhancing the ability of the organisation to identify in good time people in need of help; how to honour the courage of those who do seek help in an organisational culture that also honours resilience and capacity to keep on responding in times of danger and crisis.

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Decision-making in this domain opens another layer of complexity with its own set of interlocking problems and trade-offs:

- While considerable progress has been made in understanding the impacts of exposure to trauma and the characteristics of PTSD it remains difficult to diagnose, and it is in the nature of the injury that formal diagnosis takes time. In the initial weeks after trauma most people meet the criteria for PTSD, then over the next three months 50% recover, with recovery continuing over time. Full diagnostic criteria for the 10–15% who develop PTSD are not met until six months have elapsed, yet early intervention gives the best prospects for recovery.
- Comorbidity is common — the overwhelming majority of sufferers are likely to have another disorder such as depression, substance misuse or anxiety.
- Impacted personnel may display behavioural and performance problems that are not unique to PTSD sufferers, and therefore not necessarily indicative of PTSD.

- Organisations while necessarily compassionate also need to manage the risk of encouraging spurious claims motivated by a desire to seek compensation or to avoid being brought to account for under-performance or unacceptable behaviour in the workplace. Whilst the vast majority of personnel will operate appropriately and honestly in these circumstances, integrity of the management process is essential to maintain credibility within the workforce.
- Although knowledge about the treatment of PTSD is now strongly evidence-based and well delineated, not all individuals are helped by currently available treatments.
- Ensuring that impacted personnel are referred for the right treatment of the right illness is a continuing challenge.
- Confounding the opportunities for early intervention is a perception among first responder personnel that if they admit to post-traumatic stress they do so at the risk of their further career or, at least, their 'operational' career.

In a nutshell, the problem to be addressed is how first responder organisations can best and most effectively reconcile their duty of care to their personnel with their mission of providing acceptably prompt and effective services across the whole of the jurisdiction within which they operate.

FIRST RESPONDERS ARE AT HIGH RISK OF DEVELOPING

It is estimated that 30–40% of cases are refractory to current treatments.

CHAPTER 2:
PTSD AND TRAUMATIC STRESS — WHAT WE KNOW NOW

THE BRAIN IS LIKE A SYMPHONY ORCHESTRA. FOR SOMEONE WITH PTSD, IT'S LIKE THE CONDUCTOR HAS FALLEN OFF THE PODIUM.

Alexander McFarlane, Director, Centre for Traumatic Stress Studies and Professor of Psychiatry, University of Adelaide[2]

Introduction

This chapter draws on expert contributions to *Trauma-related stress in Australia: Essays by leading Australian thinkers and researchers*, published by Australia21 and FearLess in 2016. Unless otherwise stated, attributions refer to essays in that volume.

The 2015 World Mental Health Survey identified the long-term impact of traumatic stress on mental health as one of the major determinants of impairment and disability across the globe.[3] A further body of research has identified that PTSD mediates the physical health effects of traumatic stress as a substantial risk factor for disorders such as hypertension, cardiovascular disease, rheumatoid arthritis and dementia.[4] As well, comorbidity is common in PTSD: 86% of men and 77% of women with PTSD are likely to have another disorder such as depression, substance misuse or anxiety.[5]

Estimates put the number of Australians who live with PTSD including the 1.5 million directly affected and their immediate families as high as 3–4 million. This means a large proportion of our community endures lives ranging from tragic and/or dangerous to 'lives of quiet despair' to lives that are simply not as productive, healthy and enjoyable as they could and should be. There is also societal risk when PTSD sufferers reach the point where they cannot perform their duties safely and effectively and become a risk to themselves and/or the people they are meant to serve.[6] So the scope and scale of the problem is immense in terms of both human suffering — people with PTSD are at increased risk of self harm and suicide — and the social and economic costs of the poor mental health, drug and alcohol abuse, crime, violence, family disruption and lost productivity which can be associated with it.[7]

We now know enough to state with certainty that a significant proportion of people in certain professions, such as first responders, are at high risk of developing serious stress arising from the traumatic events in which they are involved. We need to recognise that suffering arising from such exposures is predictable and not shameful and therefore that educational efforts to prepare and support people in these professions should be substantial; easy shame-free access to treatment should be available for them should they need it.

Experts also agree that the problem is under-reported and that even when professional help is sought, not all are helped by currently available treatments. For first responders there is an additional Catch-22 — if they admit to such stress there is a widely held perception that they do so at risk to their future career.

While great strides have been made in clinical management and rapid advances in neuroscience are pointing to new possibilities for therapeutic approaches, it is estimated that 30–40% of cases are refractory to current treatments. This means that expanding our understanding of the way the brain responds to traumatic experiences and developing new treatment options must be a high priority for future researchers.

2 From an interview (Melbourne, 29 March 2017) with Dean Yates, a Reuters journalist and mental health advocate, and head of mental health and wellbeing strategy at Reuters, who generously shared his research with the authors following the Roundtable.
3 McLaughlin, KA, Koenen, KC, Friedman MJ et al, 2015. "Subthreshold Posttraumatic Stress Disorder in the World Health Organization World Mental Health Surveys" *Biological Psychiatry*, Elsevier.
4 Alexander McFarlane, "Traumatic stress: the uncounted cost".
5 Phoenix Australia (2013) "Australian guidelines for the treatment of acute stress disorder and post-traumatic stress disorder".

6 Paul Barratt, "Foreword to Trauma-related Stress in Australia".
7 Medicare has estimated that work-related stress and increased days off work related to stress cost the economy $14.8 billion annually with direct costs to employers of $10–11 billion per year (Emma Barkus, Mitchell Byrne and Alison Jones, "Post-traumatic stress: a community concern"). While work related stress is not necessarily full blown PTSD there is some overlap and these figures give some indication of the economic impact.

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About PTSD

First recognised as a syndrome by the mental health professions in the 1980s, PTSD is a debilitating and often chronic mental health condition associated with high levels of distress. It is usually triggered by exposure to traumatic situations where an individual may be placed in a life or death situation that can also challenge their emotional resources, beliefs and values.

Although the word 'trauma' is often used to describe the exposure event itself, it would be more accurate to use the term 'potentially traumatic event' (PTE). A distinction is sometimes made between Type I trauma which describes a single event, such as an assault, accident or natural disaster, and Type II trauma which describes prolonged and repeated trauma, such as ongoing domestic violence, war or severe political repression.

A series of emotions including shock and disbelief, fear, sadness, helplessness, guilt, anger and shame often follow exposure to, or involvement in, traumatic events that include threats to self or others, brutality, violence and death. The natural physical response to such emotions can include trembling or shaking, a pounding heart, rapid breathing, racing thoughts, feeling choked up, stomach tightening and churning, feeling dizzy or faint, or breaking out in a cold sweat. These can all be normal responses to a horrible event and very often they pass quite quickly. Understanding the legitimacy of such feelings and such physical responses is an important part of dealing with them and getting on with life.

Because the trauma associated with the event often shatters a person's basic assumptions held about the world, other people and themselves, it is in a sense personally defined. The same event may result in little or no adverse reaction in some people yet precipitate debilitating post-traumatic mental health issues in others. In some cases a person may exhibit no adverse reaction through a range of stressful events and then suffer a significant mental health reaction to a single similar event – even a relatively minor one – as a consequence of the cumulative impacts of such events. The powerful emotions generated by such events can become associated with a range of reminders or triggers through a process of conditioning, so for some people the symptoms persist and they may be unable to move on from the event. Eventually they may develop post-traumatic stress disorder (PTSD), with ongoing disturbing thoughts, feelings or dreams related to the event, mental or physical distress in response to trauma-related cues, and alterations in how they think and feel.

Formal diagnosis of PTSD

PTSD is defined by two major health organisations — the American Psychiatric Association in the fifth edition (2015) of its *Diagnostic and Statistical Manual of Mental Disorders (DSM-5)* — which is the most widely used diagnostic system in Australia — and the World Health Organization in its *International Statistical Classification of Diseases and Related Health Problems, 10th Edition (ICD-10)* published in 1993 and about to be updated.

DSM-5 summarises the diagnostic criteria for PTSD as including the following:

- The person was exposed to: death, threatened death, actual or threatened serious injury, or actual or threatened sexual violence, via direct exposure, witnessing the trauma, learning that a relative or close friend was exposed to the trauma, or indirect exposure to aversive details of the trauma, usually in the course of professional duties (e.g. first responders or medics).

- The traumatic event is persistently re-experienced, via intrusive thoughts, nightmares, flashbacks, emotional distress or physical reactions after exposure to traumatic reminders.

- There is avoidance of trauma-related stimuli after the trauma.

- The person experiences negative thoughts or feelings that began or worsened after the trauma, e.g. inability to recall key features of the trauma, overly negative thoughts and assumptions about themselves or the world, exaggerated blame of self or others for causing the trauma, negative affect, decreased interest in activities, feelings of isolation.

- The person experiences trauma-related arousal and reactivity that began or worsened after the trauma e.g. irritability or aggression, risky or destructive behaviour, hypervigilance, heightened startle reaction, difficulty concentrating, difficulty sleeping.

For a formal PTSD diagnosis, symptoms must last for more than one month, create distress or functional impairment, and not arise from medication, substance use or other illness. In addition to meeting the criteria for diagnosis, an individual may experience high levels of either depersonalisation ('this is not happening to me') or derealisation ('things are not real') in reaction to trauma-related stimuli. Full diagnostic criteria are not met until at least six months after the trauma(s), although onset of symptoms may occur immediately. While formal definition of the disorder is important to provide consistency of meaning for research, clinical development work and policy, there is also a need for early intervention to reduce the possibility of the symptoms progressing to become severely disabling. Should such symptoms persist for more than a month after the event, experts agree a sufferer should undertake treatment including specialist counselling and in some cases drug therapy.

Complex PTSD (C-PTSD)

Although mainstream journals have published papers on C-PTSD, the category is not yet adopted by either *DSM-5* — largely because individuals showing symptoms of Complex PTSD also meet the diagnostic criteria for PTSD — or *ICD-10*, although it is being considered for ICD-11 (to be finalised in 2018).

Those who propose C-PTSD as a distinct disorder contend that the current PTSD diagnosis may not fully capture the severe psychological harm that occurs with prolonged, repeated trauma. During long-term traumas, the victim is generally held in a state of captivity physically or emotionally, is under the control of the perpetrator, and unable to get away from the danger. Examples include concentration camps and prisoner of war camps, forced prostitution, long-term domestic violence, long-term child abuse, and organised child exploitation rings. While first responders are not generally exposed to these particular circumstances, the repeated nature of their exposure to trauma, which many report, makes reference to C-PTSD relevant in this report.

Alongside those symptoms associated with a formal PTSD diagnosis, people who experience chronic trauma may experience difficulties in the following areas:

- **Emotional regulation**, including persistent sadness, suicidal thoughts, explosive anger, or inhibited anger.

- **Consciousness**, including forgetting traumatic events, reliving traumatic events, or having episodes in which one feels detached from one's mental processes or body.

- **Self-perception**, including helplessness, shame, guilt, stigma, and a sense of being completely different from other human beings.

- **Distorted perceptions of the perpetrator** such as attributing total power to the perpetrator, becoming preoccupied with the relationship to the perpetrator, or preoccupied with revenge.

- **Relations with others**, such as isolation, distrust, or a repeated search for a rescuer.

- **One's system of meanings**, including loss of sustaining faith or a sense of hopelessness and despair.

Standard evidence-based treatments for PTSD are effective for treating C-PTSD but it may also involve addressing interpersonal difficulties and the specific symptoms mentioned above.[8]

Vicarious trauma

DSM-5 now also recognises traumatic stress conditions that can arise from indirect or vicarious exposure, e.g., to online child exploitation, and details of terrorist acts and other atrocities. The staff member is not under any direct personal threat but repeatedly exposed to details of such exposures. The DSM cites the example of a police officer who spends each day taking witness statements from victims of child abuse. There is now recognition that such exposure can exert a cumulative impact and result in the development of traumatic stress conditions. Other possible examples include forensic staff identifying bodies in the aftermath of natural disasters and war zones; child protection workers repeatedly exposed to highly dysfunctional family circumstances; postal staff who screen objectionable materials arriving in Australia by post; and lawyers and para-legal staff involved in prosecuting sexual offences. Vicarious post-traumatic stress conditions are an emergent workplace psychological health and safety risk that can be as debilitating as traditional forms of post-traumatic stress disorder.

The contribution of neuroscience to understanding PTSD

About 80% of recent research in PTSD is in the field of neuroscience. The prevailing model for understanding PTSD is the fear-conditioning model derived from the behavioural theory of classical conditioning. This model draws upon known brain functions and the evolutionary survival value of those functions. Arousal in the face of threat is mediated by the limbic system, which can be thought of as the emotion centre of the brain, with many of its actions being subconscious in the thinking and reflection processes. When faced with threat the limbic system of the brain triggers the release of hormones that tell the body to prepare for defensive action. Normally a cascade of hormones prepares the body for action, then another neurological process is enacted to calm the body down after the threat is dealt with. This go-stop process is common to us all. In PTSD something goes wrong with the stop process, which can leave the person in a permanent and distressing state of hyperarousal even when no perceived threat is present.[9] PTSD can also be characterised by flashbacks, hypervigilance, emotional numbing, mood lability, insomnia and avoidance of potentially triggering situations, and it has been associated with mild to moderate cognitive impairment, most notably reduced concentration and difficulties associated with learning and memory.[10]

8 US Department of Veterans Affairs, PTSD: National Center for PTSD, "Complex PTSD" **https://www.ptsd.va.gov/professional/ptsd-overview/complex-ptsd.asp**.

9 Mitchell K Byrne, Emma Barcus and Alison Jones, "What we know so far".
10 Jim Lagopoulos, Daniel C O'Doherty, and Maxwell R Bennett, "Neuroimaging of post-traumatic stress disorder".

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PTSD and the concept of moral injury

There is emerging clinical experience to suggest that for some people the pathway of threat-fear-terror described above is not sufficient to explain the range of clinical presentations of traumatic stress. A more inclusive approach brings in pathways associated with horror-shock-injustice-guilt and the associated moral injury.

Moral injury is psychologically violating and can derive from

- Moral pollution — witnessing gross or catastrophic scenes, including another person's suffering;
- Moral betrayal — experiencing systemic failure, injustice or blame particularly in the context of high stakes;
- Moral compromise — assessing one's own or another's action or inaction as desecrating deeply held values.

It can arouse feelings of shock, disgust, disempowerment and anger and can be experienced as a violent incursion of key beliefs about the world, oneself and other people. Traumatic stress resulting from moral injury can run in parallel with the fear-threat-terror pathway adding complexity to both diagnosis and treatment.[11]

Can PTSD be prevented?

A 2013 review compared the efficacy, effectiveness and adverse effects of interventions aimed at preventing PTSD in adults after their exposure to trauma. The authors found no evidence for 'debriefing' in preventing PTSD — and in fact it may be harmful; some evidence for a care model that combined pharmacological management and cognitive behaviour therapy; no evidence for the comparative effectiveness of drug therapy over cognitive therapy; and no evidence for the comparative effectiveness of cognitive behavioural therapy over supportive counselling. There was insufficient evidence for other interventions in preventing the development of PTSD following trauma exposure.[12]

An aspect of prevention is how exposure to traumatic stress is handled in the workplace. Byrne, Barkus and Jones say that in the initial weeks after trauma most people meet criteria for PTSD, over the first three months 50% recover and this recovery continues over time, with about 10–15% developing PTSD in the longer term. They also say that repeated exposure to traumatic events elevates the risk of PTSD. The complexities of dealing with PTSD in the workplace are well-illustrated by considering how best to manage first responders who have direct life-threatening experiences or who are exposed to vicarious trauma as an ongoing part of the job. Are they fit for duty immediately after being exposed to a potentially traumatic event, and, if not, what is a reasonable recovery time? It appears this is highly variable from individual to individual; hence there is a lack of definitive research on the best approach. Competing demands also emerge between the manager's need to try to mitigate the risks of further psychological exposure and ensure adequate rest and recovery within the broader organisational health and safety imperatives, and the individual worker's needs and wishes about returning to work, which may be also influenced by perceptions that being restricted is punitive.

Clearly, more work is needed to establish how best to advise people who are troubled by stress in the immediate aftermath of a trauma exposure, but if the early symptoms are severe, research indicates that cognitive behavioural therapy and/or drug support should be tried as outlined in the next section.

What treatments are available?

Demonstrably effective treatments for PTSD include psychological and medical interventions, but the cornerstone of treatment involves confronting the traumatic memory and addressing thoughts and beliefs associated with the experience. Trauma-focused interventions can reduce PTSD symptoms, lessen anxiety and depression, and improve quality of life. As with all treatments, it is important to develop trust and a good therapeutic relationship to obtain a positive outcome.

- Adults with PTSD should be offered trauma-focused psychological interventions. The two recommended treatments as per Phoenix and the Black Dog Emergency Services guidelines are trauma-focused cognitive behavioural therapy (CBT) or eye movement desensitisation and reprocessing (EMDR).
- Where adults have developed PTSD and associated features following exposure to prolonged and/or severe traumatic events, more time to establish a trusting therapeutic alliance and more attention to teaching emotional regulation skills may be required.
- Medication should not be used as a routine first-line treatment in preference to trauma-focused psychological therapy.
- Medication can be useful if the person receiving treatment is not getting sufficient benefit from the psychological intervention alone. It can also be used as an alternative when psychological treatment is refused or unavailable, or when the person has a comorbid condition where medication is indicated.
- Where medication is considered for the treatment of PTSD in adults, selective serotonin reuptake inhibitor (SSRI) antidepressants should be the first choice.
- A promising treatment option is emerging after years of lobbying and laboratory research on the medical uses of methylenedioxymethamphetamine (MDMA). This drug has been shown to have the potential to offer significant relief to sufferers of PTSD when combined with psychotherapy, and in 2017 the U.S. Food and Drug Administration(FDA) granted Breakthrough Therapy Designation (BTD) to it for the treatment of PTSD. This designation does not indicate approval by the FDA but it expedites the development and review of drugs that are intended to treat a serious condition where preliminary clinical evidence indicates that the drug may demonstrate substantial improvement over available therapy.[13]

In addition, there is emerging anecdotal evidence, yet to be well researched, that complementary approaches that improve quality of life may be useful to support or provide an alternative to more traditional psychological and medical interventions for some people. These are considered as adjunct approaches and include:

- Mindfulness and yoga
- Arts therapy and animal therapy
- Adventure activities and exercise
- Peer support
- Use of web-based apps
- Virtual reality exposure technology.[14]

How effective is treatment?

Knowledge about the treatment of PTSD is now strongly evidence-based and well delineated. For example, Phoenix Australia has produced "Australian guidelines for the treatment of acute stress disorder and post-traumatic stress disorder" endorsed by the National Health and Medical Research Council, and the Black Dog Institute has published "*Expert guidelines: The diagnosis and treatment of post-traumatic stress disorder in emergency service workers*". However a recent audit of clinical practice in one State found that the skills needed to provide state-of-the-art psychological therapy are not always available to those who are managing the patient. Less than 50% of treatments reviewed in that State were consistent with PTSD clinical guidelines.[15]

There is also a gap in getting to the right treatment for the right illness. The first contact is often with GPs, who frequently lack the skills or expertise to appropriately diagnose PTSD, or may not be across best practice in this area. This can flow on to the referrals for treatment.

Against that background, there is recognition that not all victims of PTSD are helped by currently available therapies, even when provided by therapists using best practice. Outcomes are better for women, non-veterans and people with single rather than multiple/complex exposure.[16] In general terms, about one third of people with PTSD recover with treatment, one third gain significant benefit but are still symptomatic, and one third gain little benefit. The challenge is to improve these ratios.

[11] Dominic Hilbrink, David Berle, Zachary Steel, "Pathways to posttraumatic stress disorder".

[12] Forneris C A, Gartlehner G, Brownley K A, Gaynes B N, Sonis J, Coker-Schwimmer E, Jonas D E, Greenblatt A, Wilkins T M, Woodell C L, Lohr K N 2013 "Interventions to prevent post-traumatic stress disorder: a systematic review" *American Journal of Preventative Medicine*.

[13] https://www.forbes.com/sites/janetwburns/2017/08/28/fda-designates-mdma-as-breakthrough-therapy-for-post-traumatic-stress/#26066c087460; http://www.newsweek.com/mdma-ptsd-therapy-enters-final-round-trials-could-be-approved-us-and-canada-786309 accessed 11 April 2018.

[14] David Forbes, Andrea Phelps, Jane Nursey and John Cooper, "Navigating a path to more effective treatments".
[15] Peter Cotton, "Do sufferers get access to effective treatments?".
[16] David Forbes, Andrea Phelps, Jane Nursey and John Cooper, "Navigating a path to more effective treatments".

Unanswered questions and challenges

Experience of a PTE is not unusual and around 75% of Australians experience at least one of these events in their lifetime. The vast majority of people who experience stress related to that event recover from it within weeks or months, with the help of family and friends and by using their own coping strategies. Only a minority go on to develop significant mental health problems such as PTSD.

It is difficult to predict why some people go on to develop PTSD and others do not, but some of the factors include repeated exposure without recovery time, exposure to consequent stressors (e.g. legal proceedings, occupational problems, financial concerns, media scrutiny) and availability of support. Intrapersonal issues can also play a part including prior psychological problems and psychopathology in the family of origin. Although many people with PTSD recover in the first 12 months, even with the best treatment currently available around 30–40% of the remainder require different approaches and often go on to show a chronic course over many years.[17]

We hope that recognition of the importance of this issue for Australian first responders will lead to an expansion of research into improved methods of workforce education, early recognition, expert treatment and evaluation of various approaches to intervention.

However, there are several significant barriers to effective treatment of PTSD. Many people find exposure-based treatment distressing, therapists find it difficult, and many are unskilled in using it. Perhaps the most important problem is reluctance by those experiencing PTSD to seek help or to recognise their need for help. This often relates to the perceived stigma of having a mental health problem or lack of community knowledge about mental health issues, and that it is normal to experience emotional reactions to traumatic events. This requires not only change in first responder organisations but also change in community understanding about first responder occupational stress.

For people in the first responder professions and in the Defence forces, exposure to serious life-threatening events is part of the job specification. Small wonder that many of them suffer stress symptoms following particular professional duties. And small wonder also that they will be disinclined to want to seek outside help if they perceive the consequences of doing so could prejudice their continuing employment prospects.

One of the difficulties in organising effective interventions is that responsibilities for those at risk are spread between government departments such as Defence, police, family and community services, health and the criminal justice system. There is also a concern among employers to minimise compensation costs. Prevention and treatment services are often poorly coordinated across organisations within a state, let alone nationally. There is not — and needs to be — a national strategy for developing consistent high-quality evidence-based systems of prevention and treatment for at-risk populations.

This field has developed enormously in recent decades but there are still many unanswered questions in relation to prevention and treatment. As well, we need to understand much more about the epidemiology of PTSD among first responders and the workplace issues that can mitigate or worsen its effects. Finally, we must acknowledge both the moral responsibility to respond to this cry for help from those we depend on for assistance in times of crisis, and the huge costs to the community if we do not.

CHAPTER 3:
GAPS AND CHALLENGES

Introduction

In embarking on this project we already knew that PTSD is a huge issue for first responders and for first responder organisations that manage it as part of looking after their staff and maintaining organisational capability. In March 2016, at the commencement of the collaboration between Australia21 and FearLess Outreach, Paul Barratt and Admiral Barrie had attended *beyondblue*'s Sydney conference for leaders of first responder agencies, addressing the mental health and suicide risks faced by their workers.

It was clear that much had been and was being done, and that knowledge was actively shared between first responder agencies, both directly and via organisations like *beyondblue*. It was equally clear there were knowledge gaps where further research needs to be done; management challenges — managing the first responder workforce in such a way as to minimise the risk of mental as well as physical injury; service delivery challenges — ensuring that affected first responders are identified promptly and given the highest quality treatment; and gaps in the national policy frameworks which should facilitate the best and most cost-effective responses to the unavoidable traumatic stress that first responders face.

It needs to be acknowledged that managements of hard-pressed and often under-resourced first responder organisations do make it a priority to deliver to affected personnel the highest quality services that can be provided on the basis of currently established knowledge. Neither Australia21 nor Fearless Outreach is in the business of duplicating or second-guessing the activities of others, and we do not seek to intervene in this 'here and now' process being run by qualified people within an established chain of command.

What we have sought is to sit in the space between individual first responder organisations that are doing their best to look after their people, on the one hand and, on the other, the academic mental health research community seeking a better understanding of PTSD and how to treat it. Our intention has been to approach the issue at a strategic level, to develop new frameworks of understanding about how prevention, diagnosis and early intervention can be achieved, along with best practice treatment and rehabilitation where required; and to make recommendations to that end — the aim being to help keep first responder personnel physically and mentally fit in the workplace, with post-injury treatment coming into play only when best efforts at prevention have failed.

To this end, we brought together senior managers, operational managers, affected front-line personnel, occupational health and safety experts and researchers, to stocktake the state of play and to answer questions like:

- What additional knowledge would assist first responder organisations to manage the issue more effectively?
- What organisational approaches would enable the risk to personnel to be minimised?
- How do we go about effective early identification of affected personnel, with a view to prompt treatment and complete cure?
- What are the confounders, the things that get in the way of implementing best practice as we know it?

Knowledge gaps

A review of the Roundtable discussion identified a number of knowledge gaps:

- How best to manage exposure to minimise the risk of people becoming injured in the first place
- How best to advise people who are troubled by stress in the immediate aftermath of a trauma exposure
- How to predict why some people go on to develop PTSD and others do not
- How to broaden understanding about the epidemiology of PTSD among first responders and the workplace issues that can mitigate or worsen its effects.

As already noted, not all victims of PTSD are helped by currently available therapies, even when provided by therapists using best practice. While one third recover with treatment and one third gain significant benefit but are still symptomatic, the final third gain little benefit.

17 Mark Creamer, "The impact of stress and trauma on mental health... more than PTSD?".

Managerial challenges

Our review also identified a range of challenges for consideration by first responder organisations:

- Managing exposure is and will remain an enormous challenge, especially in the small stations in regional and remote areas served by first responder organisations. These small stations do not have the resources to manage staff rotation, and they do not have the same access to expert treatment that stations in metropolitan areas have.

- There is a profound reluctance among operational staff to seek help, because they assume this will be disastrous for their careers. Normalising the mental health consequences of dealing with confronting situations, so they can be talked about openly, is a key challenge.

- There are management issues associated with training operational managers on the known impacts of trauma-related stress and approaches to managing its effects; how to deal with impacted staff, whether that be in the context of their first seeking help or return to work, and with the return to work itself.

- There are resourcing challenges for senior managers in bidding for the resources required to enable them to manage exposure by providing the resources which will enable their operational units to provide the responses expected by the public they serve in a manner which is as safe as possible for their personnel.

Policy challenges

And finally, there are some important framework issues to be addressed by senior management:

- Developing an organisational culture that genuinely recognises and embraces that "helping hurts" and that stress-related trauma is simply a reflection of the work and demands that are the first responder workplace.

- Arrangements to minimise the impact of inquiries or legal proceedings consequent upon an incident on the individual(s) involved, and of media intrusions. While the processes are afoot, the individual(s) concerned should be shielded by their organisations from avoidable pressures.

- Ensuring that the compensation processes for personnel affected by PTSD are not such as to exacerbate the mental stress of the individuals concerned. This might require a legislated presumption that, if a worker is exposed to certain types of traumatic events and is diagnosed with PTSD, it is caused by the worker's employment, unless the contrary is proven[18].

- Development of a more structured mechanism for sharing information on good practice across first responder jurisdictions.

- Development of a national system for gathering standardised epidemiological data about the incidence of PTSD in first responder organisations.

- Development of a national policy framework for dealing with PTSD in first responders.

- Development at the national level of appropriate education and training materials.

- Campaigning to strengthen the national research effort.

- Putting the matter on the national political agenda.

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[18] Workers Compensation Board of Manitoba, PTSD Presumption, at **https://www.wcb.mb.ca/ptsd-presumption-0 - Footnote** accessed 9 March 2018.

THE GAPS AND CHALLENGES IDENTIFIED ABOVE

are only indicative of the issues we unpack and discuss in the chapters that follow.

HELPING HURTS

The requisite organisational culture is one that genuinely recognises and embraces that stress-related trauma is simply a reflection of the work and demands that are the first responder workplace.

THE ROUNDTABLE DISCUSSION

THE LAYERING OF SUICIDES, CAR CRASHES, SUDDEN DEATHS

that you attend as a first responder takes its toll
and leaves you with dents in the soul.
A Roundtable participant

CHAPTER 4:
THE VOICES OF LIVED EXPERIENCE

Introduction

The voices of lived experience at the Roundtable included currently serving operational personnel, some very senior personnel who were impacted earlier in their careers, and some personnel no longer serving who counsel and assist impacted personnel and in some cases their families. The voices of those who deal face-to-face with impacted personnel, to assess, assist and where necessary refer for treatment, were also included.

The voices of those who have lived through the experience of PTSD or its triggers or precursors in the course of their duties are vital to developing better frameworks for managing the issue. They also indicate how well their organisation manages the issue. If impacted personnel say their organisation's response was timely, respectful, courteous and effective, we can be fairly confident the approach was sound within the constraints of current knowledge.

The discussion which follows is based on what impacted personnel at the Roundtable said about their experiences, including the trigger events, their realisation that there was a problem, their organisation's response, the psychological/medical treatment they received, the impact on family and personal life, factors that made their situation worse, and improvements they would like to see. The voices from first responder communities and Defence are referenced in later chapters.

It wasn't possible to debate every point made by every participant at the Roundtable because of time constraints, but alternative views were expressed at several points of the proceedings. For the summary that follows, we have selected the views we think most of the participants would regard as reasonable, a choice that was largely validated when the draft was circulated for comment. That said, Australia21 and FearLess take full responsibility for the text and its conclusions and recommendations.

First responders accept that exposure to confronting situations is inherent in their jobs, that there will be times when they are personally at risk, and that there is a significant probability that over the course of a career they will face situations at the extreme end of the spectrum. In some callings — e.g. homicide squad, police and ambulance attending road accidents — this exposure is regular.

These situations are the *raison d'être* of first responder organisations, and the organisation cannot control them, just as it cannot control the impact of genetics and family of origin issues on first responders. The organisation can, however, control how they screen recruits, how they prepare people to deal with scenes of horror, the operational tempo for individual members (most of the time), their expectations of personnel regarding looking after their own physical and mental health, how they identify that a staff member has a problem, the clinical support they provide to those who need it, the emotional support they give to impacted personnel and their families, the return to work (RTW) arrangements, and how the issue is spoken about in the workplace.

Key points

Some key themes emerged from during discussion. As noted above, first responders accept that exposure to confronting situations is inherent in their jobs, and that there are times when they will be personally at risk. They accept that they need personal stamina and that they need to be resilient, and they take pride in their resilience and ability to cope with these stressful, distressing and at times threatening situations. These individuals are often very good performers, they push themselves harder and faster every time, and they will be the last to accept fragility in themselves and the last to seek help. This compounds the problem.

However, several spoke of the impact of too high an operational tempo. People who are well-equipped physically and mentally to deal with any individual operation can find themselves dealing with situations in too rapid succession and for too long, compounding the stresses inherent in their duties by insufficient time between operations to unwind, as well as by insufficient and poor quality sleep, so that their coping mechanisms are compromised.

This situation can also arise from spending too much time on call — one participant who was effectively always on call referred to experiencing a stress reaction every time his mobile phone rang. The lack of 'down-time', whether due to being on call or engaged in operations, compromises not only the capacity to recover before the next call-out, but relationships within the family and with friends. This can be cumulative, possibly over many years, and can occur at all levels of seniority.

People not only need time to recover, they need sufficient time they 'own' to enable them to lead normal lives — to be able at least some of the time to plan weekend activities and be 99% certain they will be able to carry them through. Everyone accepts that plans will be thrown into disarray at times of emergencies such as cyclones, floods and bushfires, but they want and need greater control of their lives outside those enforced peaks of activity.[19]

Another important theme is people's uncertainty about what will happen if they speak up about being under stress and the fear this will end their careers. This leads to personnel attempting to hide their problem, doing everything they can to avoid being seen as 'weak'. The behaviours exhibited included:

- Tuning out emotionally — 'wearing a mask at work'
- Over-compensation: being the first to arrive at the office and the last to leave, always being available for everything, always prepared to be on call or to fill in when a hole needs to be plugged
- Becoming socially withdrawn, having difficult relations with family and/or workplace colleagues
- Feelings of paranoia and suspicion of others
- Drinking too much and drinking alone.

Personnel attempting to cope entirely on their own resources also reported poor quality sleep, nightmares, flashbacks, and digestive problems. It may reasonably be assumed that all of these behaviours and physiological reactions compound the problem: certainly none of them helps.

There was acknowledgement that earlier disclosure could have averted the development of PTSD, and that the organisation has a role to play in ensuring that the individual feels comfortable to acknowledge stress and receives access to timely treatment.

Another factor that made personnel reluctant to speak up is a perception there is stigma attached to being diagnosed with a mental health condition, although this seems to be less of a driver than concern about the impact on career. There was a consensus that the impact of operational situations on mental health needs to be accepted as part of the job and discussion of it normalised. All acknowledged that stigma is an issue, but some participants felt there is a limit to what can usefully be done about it — that whatever is done to raise awareness and reduce stigma will never be enough, and that there comes a point at which any additional resources would be better spent on treatment of affected personnel.

There was a consensus that the support of family and friends in coping with the occupational stress is important, but this raises a difficulty for police in particular because they feel unable to disclose what they are involved in and hence what is troubling them. There was a view that operators need to be able to disclose to their partners — in very general terms — what the source of the stress is, as part of the process of dealing with it and putting it behind them.

Whatever difficulties there might be in relation to disclosure of particular events, participants felt first responder families should be offered awareness education about the sorts of stresses inherent in first responder occupations, about the nature of PTSD and about its symptoms. We believe that this awareness can only assist intra-family relationships in difficult times.

Support of peers is also important for personnel impacted by PTSD. Some reported that they didn't wish to be 'off work' — they wanted the normality of turning up for work, being surrounded by colleagues, and having things to do that needed to be done. Some who had been off work also commented on the isolation of this, which led them to question how much they were valued by their employer; one person reported that no one from the workplace had made contact over a period of six months' sick leave.

Regarding the condition itself, there is clearly no 'one size fits all' and training needs to emphasise this. Some people are affected by a single extreme event (perhaps on top of other disturbing experiences), some are affected by the accumulation of distressing experiences over time or the insidious effects of, for example, spending hours every day looking at distressing images for the purpose of identifying victims of horrific child abuse. Some are affected very promptly by the trigger event; some are affected years later.

Several messages emerged regarding preparations and training that would better equip personnel to deal psychologically with the confronting situations they are bound to experience. One participant said personnel needed to be better trained for the situations they will face; their training needs not only to cover technical skills but also to make them fully aware of the potential impact of situations they are likely to confront. Others added that it also needs to provide basic information about the neuroscience of traumatic stress reactions and how best to deal with them.

First responder self-management strategies in relation to health and wellbeing (including fitness, sleep, nutrition and spiritual wellbeing — defined not in a religious sense but in the sense of capacity 'to live in the moment'[20]) were also recognised as important contributors to resilience.

Return to work (RTW) presents a number of issues. Some supervisors are unsure how to relate to impacted personnel, due to lack of relevant training. The comment was made that people tend to be promoted on the basis of their technical skills rather than their people management skills. Officers assessed as fit to return to work may nevertheless have some difficult days. Colleagues and supervisors need to be prepared for this. It was suggested that the best way for impacted personnel to deal with the return to work is to be open and honest about their condition.

What they said

Operational tempo and wellbeing

Comments made by impacted personnel emphasised an important relationship between operational tempo, opportunity to recover, quality of sleep, nutrition and personal health, and family and social life.

The continuous nature of the work was contrasted with the need for time to recover from operations — as one (impacted) participant put it, 'I was really, really exhausted all the time and could never catch up' for lack of sleep.

Exposure to horror was an additional factor:

With the exposures to the horrific scenes on top of that, it just built up.

Another factor for that participant was lack of training (presumably a lack of preparation for the types of scenes the operator would encounter, regardless of what other training they might have had in the process of their qualification or induction training).

Another commented that all operators have acute and ongoing stress, and they need down-time. As that participant put it:

Our people need enough time to recover from operations and just to rest from work — to turn the phone off, to have time with the families to do what they do. Not all operators have PTSD but they certainly have large periods of acute stress. They are never not stressed.

Another (senior) participant commented that mental health needs to be treated in line with physical health. For this participant mind, body and 'soul' (in a spiritual not religious sense) are interconnected and a holistic approach is required. This requires attention to fitness, nutrition, sleeping patterns, and spirituality in the sense of being grounded or able to 'live in the moment'. Getting those settings right need to be factored into the organisation, which means giving people both the opportunity and the responsibility to look after themselves; it will not happen simply by telling operators it is beneficial.

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19   In the Whitehall studies (1967–88), Michael Marmot, Professor of Epidemiology and Public Health, University College London, studied 10,000 British civil servants and found a dramatic difference in disease between those at the top of the hierarchy and those at the bottom. Data analysis eventually found that the difference related to control of destiny. The lower down the pecking order people were, the less opportunity they had to influence the events that impinged on their lives and that's what chronically stressed and sickened them. While this study identified seniority as a protective factor, the inability to control their destiny may be a universal factor impacting all levels in first responder organisations.

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20   The phrase 'live in the moment', while having a 'new age' ring to it, is a technical term that refers to the wellbeing of being grounded mindfully in the present. There is a body of literature on this and there are well-established training techniques to assist people to achieve it. The research on the science of 'being in the moment' and mindfulness practice has steadily increased as studies continue to find beneficial effects. Much of this research originally came from medical specialists, such as Prof Jon Kabet-Zinn (see **www.mindful.org/no-blueprint-just-love**). In the late 1970s he was one of the first and foremost clinicians to bring mindfulness into the clinic to help his cancer patients. Now the benefits of mindfulness, which include an improved capacity to calm the anxious mind and fearful emotions, are being applied outside hospitals. In these settings, research has found lower levels of stress and bullying, and higher levels of attention and creativity among those practicing mindfulness. Mindfulness is not without its detractors in some circumstances, particularly if not taught by trained people, or if stripped of its ethical origins. This specific criticism notwithstanding, research into mindfulness is continuing and, in the first of its kind, the University of Massachusetts Medical School has just announced the creation of a new academic division dedicated to the study of mindfulness. The Division of Mindfulness encompasses the university's existing Center for Mindfulness in Medicine, Health Care, and Society (website **www.umassmed.edu/cfm/**), started by Jon Kabat-Zinn in the early 1980s.

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The manifestation of symptoms

The point was made that there is no 'one size fits all' for PTSD, and this is consistent with the literature. One participant reported that the onset of PTSD was years after the trigger event, another that the symptoms were already 'cemented in' by the time the condition was diagnosed:

Relationships with my wife and children were failing. I was drinking alone, and to excess. I was having trouble sleeping, and when I did sleep I was having nightmares. I was having flashbacks, my thoughts were paranoid and suspicious and my perception of reality had become a mish-mash of reality, horrible thoughts, flashbacks and nightmares. I had become hypervigilant, irritable, withdrawn and felt everyone else was out of step. The physical symptoms included night sweats, severe digestive problems and fatigue.

The person for whom the onset was years after the event reported:

I had no symptoms at [the] time [the operation was completed] and had always prided myself on my resilience. My PTS symptoms exacerbated over time, I was unwilling to share the details with friends, family or medical practitioners.

Separation from work

Health care professionals at the Roundtable acknowledged there are different views in the research literature about whether PTSD is a permanent versus a curable illness, but it is clear that the symptoms of PTSD are not easily reversible. While going to work might make a person ill, ceasing duty will not in itself lead to improvement. Several participants said that they did not want to stop coming to work, where they would have colleagues and a sense of purpose, and some reported a very difficult time when they ceased duty:

After stopping work, I experienced the following feelings and emotions daily: guilt, failure, uselessness, laziness, helplessness, anger, sadness, confusion. I felt that 18 years of hard work and dedication had amounted to nothing. My personal life was a mess, I had no qualifications useful outside the police, and my future was looking bleak.

Another referred to the sense of isolation while absent from the workplace and one senior psychologist reported:

What [retired officers who have been off work] have said to me again and again is 'No one ever called me. I was off six months and no one ever called'.

We can be sure this is occurring more widely than in one organisation.

Mitigation and treatment

Consistent with there being no 'one size fits all' for PTSD, there is no 'one size fits all' for treatment. People's pathways into the problem will vary, and their ways out of it will be just as variable. One participant said:

I chose not to be medicated, but after extensive counselling, identifying specific areas of moral concern and putting strategies in place to mitigate these negative feelings and emotions, I was able to rebuild my personal life and ultimately return to work. The support I received from supervisors, colleagues and RTW staff, as well as family and friends, was a significant contribution to my recovery.

It is clear that the earlier impacted personnel are identified, the better their prospects for treatment and returning to fully effective work are, and this was acknowledged. One participant who had hidden the condition for 15 years commented:

Yet in 15 years there were a lot of opportunities. I could have been steered back and managed in a less traumatic way and not even had PTSD.

Regarding treatment, the person who reported the delayed onset said:

… when I was diagnosed with PTSD I did receive significant support from my immediate supervisors and commissioned officers. I initially found it difficult to find appropriate treatment professionals but with the assistance of [my] Police Association I was eventually referred to a treatment professional suitable to the condition.

The resilience paradox

As already discussed, dealing regularly with very confronting scenes is part of the job of a first responder. This means that first responder organisations will be looking to recruit resilient people, and it can be expected that members will be proud of their resilience and see it as part of their professional makeup.[21] This is to be expected on the part of both the organisation and the individual, and is fine as far as it goes, but we need to consider the possibility that resilient people might be the last ones to admit to themselves that they have reached their limit, and the last to put their hands up and seek help. As one front line operator put it:

Post-incident I would not let 'it' stop me. I never took a sick day as I thought [my branch of the service] would find out and determine I was weak. I hid my exhaustion, anxiety and insecurities by wearing a mask at work.

Another said:

I didn't believe I had PTSD, I just believed I had become a mongrel. I decided I was becoming soft and therefore I needed to volunteer for every job I could get to and I was a fantastic performer in the office — you would never have known I had a problem.

The issue to be alert to is that the resilience that enables first responders to keep coming back for more might have the perverse result that they break more catastrophically when they reach their later breaking point.

The confounders: about speaking up

Apart from the resilience paradox, one of the key problems confounding organisational goals of early identification and treatment is reluctance to speak up. As one impacted operator put it:

I didn't deal with it for 15 years and I didn't deal with it because I was extremely career orientated, and to me it was black and white — if I put my hand up they'd be showing me the exit door one way or the other.

Another made a similar comment about uncertainty as a confounder:

I had no idea of what the process would be if I put my hand up.

Yet another referred to his skill at hiding his condition — 'I was the best liar around' — and part of the performance was to 'work all the time, be available 24/7, never turn the phone off, go the extra yard all the time.' An operative who had returned to work described how uncertainty acts as a barrier:

I'm now operational again and since I've been back to work I've been approached by other members who want to put their hands up but just can't bring themselves to because of fear of the unknown. They don't know how they could be managed so they won't put a toe in the water.

Several others referred in this context to the stigma and the need to normalise discussion of the mental health issues for first responders. As a senior impacted police officer put it:

I think we must break the stigma, because in my experience it was the stigma that held me back — the unofficial truths and the bush telegraph around organisations. It is the misinformation that stops people coming to get help. I want to normalise the impact of mental health for first responders so that it becomes part of the normal vernacular.

About stigma

This brings us to the issue of stigma, concerning which there were many views. It was clear that front-line personnel feared they would be branded and/or shown the door if they spoke up — thereby delaying diagnosis and the prospects for successful treatment. Consistent with the comments above about the resilience paradox, part of the issue is the operator's self-assessment, but part is also how they feel they will be seen by others:

The stigma is an internal one but it's also an external one for emergency services and it's also a community one. So you feel like you don't want to tell anyone.

While recognising that perceptions of stigma were real, participants generally preferred talking about barriers to getting support rather than stigma per se, as this facilitated a more active way of identifying and implementing the changes in behaviour they saw as desirable.

Regarding destigmatisation, one impacted operator said:

I believe a lot of destigmatisation comes from the person with PTSD just being honest with people. If people then want to walk away from it, that's their choice, but if you've got good people around you they'll help you through it. … The destigmatisation and normalisation comes with honesty and lowering the boundaries yourself to help people come to accept that this can be part of the workplace nowadays.

One impacted person felt that stigma stemmed from a lack of education. Some felt there is too much focus on 'stigma' in the mental health world. One senior psychologist commented that stigma is just one of many negative attitudes and beliefs that are difficult to control, and rather than try to control them we should put our effort into the behaviours we want to see, the outcomes we want, and what we are wanting people to do differently. This person questioned whether additional resources that might become available would best be applied to further efforts in awareness training and stigma reduction or to issues like treatment standards. How much awareness training is enough, and how would we know we are doing enough?

In a similar vein, another impacted person commented that it is better not to use the term stigma and simply accept that there will be people who take a view that because you have a mental illness you are less of a person:

If you accept what is, and not focus on it, then I think we'll destigmatise the whole thing. In the mental health world there is so much focus on stigma as the cause of so many problems and issues, but is it really? As men, as human beings, we don't like to admit that we have imperfections or problems and I'm sure those things have caused us to react in certain ways that are detrimental to our health. But let's just accept things and work on those things that show a person can act in a positive way rather than a negative way.

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[21] Resilience is a concept used in a range of disciplines and societal contexts, with different precise definitions in each of them. Broadly they all refer to the capacity of a complex system to absorb a shock and retain its identity, continuing to perform its intended function. In psychology, the most relevant discipline here, it is the process and outcome of successfully adapting to difficult or challenging life experiences, especially highly stressful or traumatic events. Resilient individuals tend to exhibit optimism, self-efficacy, a sense of mastery, a sense of coherence, and hardiness. See Steven Cork, Brian Walker and Ross Buckley, *How Resilient is Australia*? Australia21 Discussion Paper, February 2008, p. 30. Report is available for download at **http://australia21.org. au/research-archive/our-research/building-australias-resilience-2/ how-resilient-is-australia/#.WTenAckIHXQ**.

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Another referred to 'the continuum of mental health' and the need to accept that everyone has their ups and downs:

If we moved our language and our focus to 'everyone is somewhere on a continuum of mental health' then the stigma goes away because we've actually normalised the fact that we all have ups and downs in our lives, we all have periods of depression, we all have periods of ecstatic joy. If we focus on that rather than 'you're on that line and everybody else is off that line' then the stigma will go away. So it's that normalisation when everyone realises that they will have times in their lives when they feel like they're falling apart and other times when they feel like they've got it all together.

A senior police officer suggested that stigma could best be dealt with in the context of changing the organisational culture to be more inclusive and embrace diversity:

When we start talking about changing the culture to one that is inclusive and embraces diversity so we get the best out of people, and where we care about people's welfare and wellbeing, you've dealt with the fundamental part, so you don't have to have the conversation about stigma. People don't want to be branded as something e.g. a whistleblower — they just want to tell their story, people don't want to be branded as a victim of domestic violence — they just want it to stop, they don't want to be a victim of bullying — they just need it stopped. This is a bit the same. One of the things that impacts on mental health is how people are treated in the workplace, so if we get a conversation going at the front end about diversity and inclusion — their responsibility for it and our responsibility for it — we can deal with this.

Not everyone agreed that stigma was not an issue to be dealt with directly. One very senior police participant said:

I don't necessarily agree that stigma is not an issue to be dealt with. I saw a lot of things in my career that were severely stigmatised in earlier times and about which more should have been done, and eventually more was done and they ceased becoming stigmatised, for example AIDS. The world does change. Some of the attitudes that I went with to [the jurisdiction in which I worked] and lived with in the 60s wouldn't be countenanced for five minutes now. And people said, 'It is what it is'. Well it wasn't what it was and it didn't have to stay what it was. So I think there's a lot we are not doing at the moment, but I take your point about not just focusing on PTSD, there are many other issues in our workplaces that attract stigma.

Return to work

Consistent with the notion that there is stigma attached to a PTSD diagnosis, returning to work presents issues for both returnees and supervisors; some of the latter will not know how to deal with this situation if they have had no prior experience and no relevant briefing or training. One returnee said that the best way to deal with this is to be open and honest about it:

I am very honest with people. When I moved areas 12 months ago, the first thing I did with my supervisors was to take them aside and say 'I have PTSD. This is what it looks like, this is how it may manifest itself and this is what may happen. I want you to know that and if you can deal with it when it happens next that's great. If you think you can't, we can sit down and talk about it.'

This same person referred to experiencing a couple of panic attacks following return to work, but said that sometimes all that is needed is 'just someone to ask if you are okay and can they help'.

Recovery and the possibility of post-traumatic growth

Many stories about PTSD emphasise the suffering and pain involved. Somewhat counter-intuitively, more than one participant referred also to 'post-traumatic growth'[22] — the experience of significant personal change and growth as part of recovery from the trauma. As one experienced manager and practitioner said:

We often don't acknowledge Post-Traumatic Growth (PTG) and a lot of people have never even heard of the term. Despite the research on resilience and PTG, the dominant discourse for many first responder agencies is based upon a purely pathological view of exposure to trauma.

I have attended a number of incidents that were confronting at the time — ones to which I was able to relate personally or ones which significantly challenged my values, sense of self or worldview. Whilst they resulted in acute stress reactions consistent with Post-Traumatic Stress these reactions only lasted for a short period and did not result in PTSD. This is consistent with the majority of [staff in my organisation]. Only a very small percentage suffer from PTSD and most experience increased resilience and Post-Traumatic Growth (PTG).[23]

A former serving member added:

I'm not all fixed up. I'm a work in progress. But I am a good example of post-traumatic growth. I've done a lot of work on myself, enabled myself to have a healthy lifestyle, and what I've seen over the years after dealing with lots and lots of police worldwide with post-traumatic stress is that there are a lot of things we can do to improve our lifestyle to go back to a healthy and happy life. It doesn't have to be a life sentence — you don't have to end up becoming an alcoholic or self medicating on prescription medications or losing our families — all the things that come with PTSD.

Another person shared their journey to recovery in this way:

... these are profound life experiences, I think they're transformational. We see them as illnesses, and part of it is, but that's not all of it. I think the whole picture is the transformation, so I say to anyone who's been through it, advocate for that and have the courage to speak it.

Ironically, everyone I've spoken to who's been through this and got out the other side — it's very hard when you are in the middle — has said 'You know I wouldn't change it for the world' because they changed, because they transformed through the process. I only get to say that because it was 23 years ago that it happened. It took me 18 years to speak of it and 20 years to not get upset by it. So when you get through it, understand the transformation and advocate for people going through it to keep going because it is a transformation of soul and it is a transformation of mind. Part of it is an illness, but not all of it, and ultimately it's only when you get there that you realise that the whole damn thing was all worthwhile — but I hope I never have to go through it again!

Conclusion

While we have ended this chapter on a note of transformative growth, albeit in one case achieved over a difficult 23-year journey, the cries and suffering of so many first responders still struggling to deal with the workplace hazard of traumatic stress cannot be ignored. As described in the chapters that follow, a start has been made to address these issues in many first responder organisations but much remains to be done. The community owes these men and women a huge debt. We expect them to be ready and available at all times day and night and in all circumstances. The least we, as community members, can do in return is listen to what they are telling us and support initiatives that will allow our them to stay healthy and capable of continuing to do the demanding job we ask of them.

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22 **Post-traumatic growth** (PTG) is a theory about transformation following trauma. It was developed by psychologists Richard Tedeschi and Lawrence Calhoun in the mid-1990s, and holds that people who endure psychological struggle following adversity can often see positive **growth** afterward. It is not about returning to the same life as experienced before the trauma, it is about undergoing significant 'life-changing' psychological shifts in thinking and relating to the world, that contribute to a deeply meaningful personal process of change.
23 This organisation has had a comprehensive education and support program in place for mitigating the effects of trauma on its personnel for a number of years.
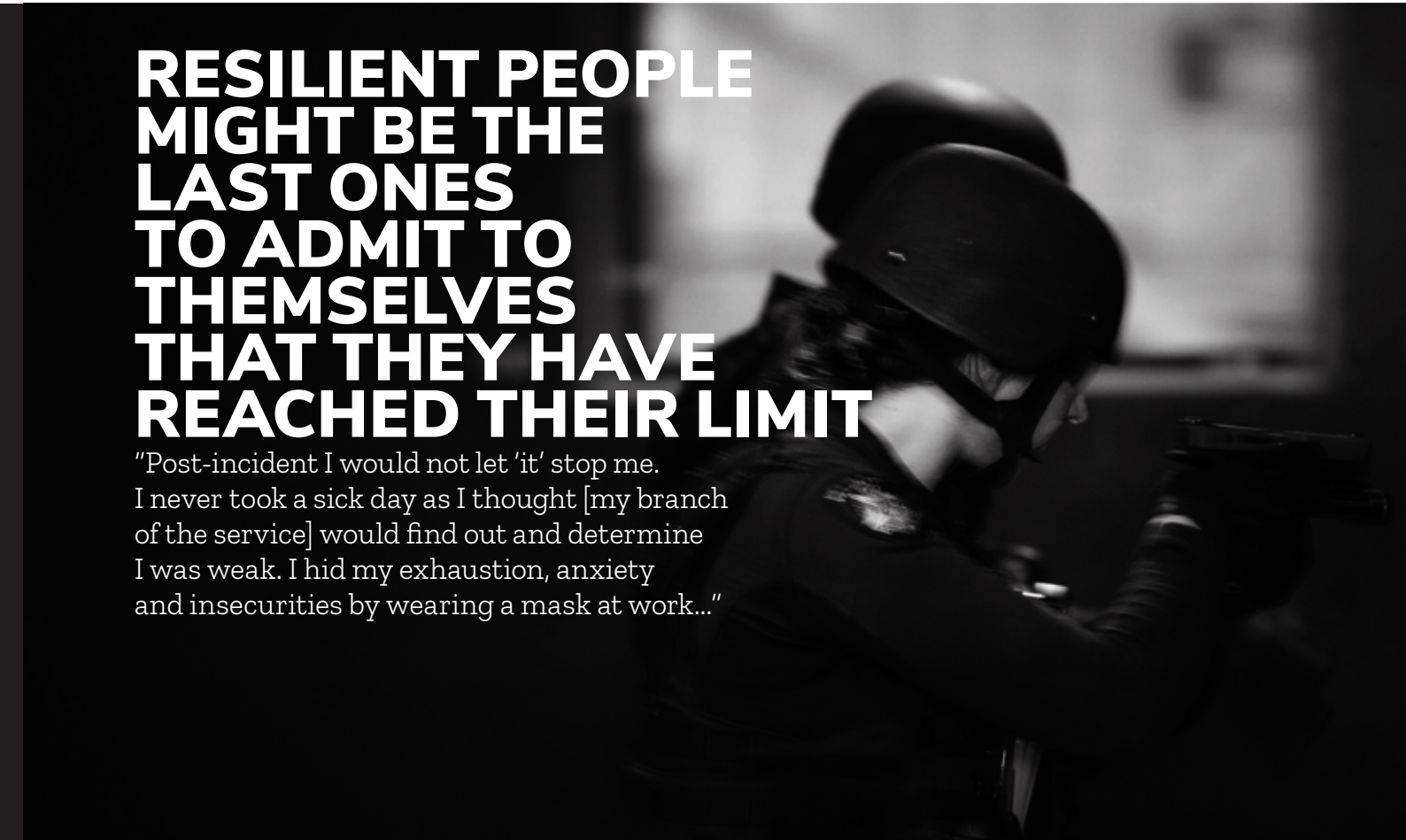

RESILIENT PEOPLE MIGHT BE THE LAST ONES TO ADMIT TO THEMSELVES THAT THEY HAVE REACHED THEIR LIMIT

"Post-incident I would not let 'it' stop me. I never took a sick day as I thought [my branch of the service] would find out and determine I was weak. I hid my exhaustion, anxiety and insecurities by wearing a mask at work..."

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CHAPTER 5:
GETTING THE ORGANISATIONAL SETTINGS RIGHT

AT THE STRATEGIC LEVEL WE NEED TO REINFORCE THAT HAVING HEALTHY PEOPLE IS ACTUALLY AN ORGANISATIONAL OPERATIONAL CAPABILITY ISSUE. IT IS NOT A CARE FACTOR ISSUE. IT'S ACTUALLY SOMETHING CRITICAL TO THE CAPABILITY OF AN ORGANISATION.

A Roundtable participant

Introduction

This chapter focuses on the views of those who have direct responsibility for ensuring that first responder personnel are equipped to do the job required of them and that, despite the potentially traumatic stress of their operational environment, they do so as far as possible without compromise to their health and wellbeing. We outline here their views on the issues, on what is working and examples of good practice, and what they would like to see changed, or are in process of changing.

The first point that needs emphasis is that the role and impact of the workplace has been dramatically under-recognised. From practice experience and traumatic stress research we know that access to social support influences mental health, so perceptions of workplace support can have a profound impact on the trajectory of trauma responses, including the development of and recovery from PTSD.

However, it is not just about a caring response to individuals, important as this is. The quote at the head of the chapter was chosen because it neatly encapsulates another important theme: having healthy people is critical to the capability of the organisation.

Framing the approach around capability can also facilitate a stronger response from management. As a senior professional commented:

I've learnt that I need to translate a lot of the concepts that I'm using into language that can be used in the organisation. If we have a discussion with our [senior managers] in their training courses about mental health, they will be intrigued, they want to know the diagnoses and all those sorts of things. But it wasn't until we started asking the question about what keeps them awake at night that we got to the real issues — and it was about risk, it was about the resources, and the capability.

So it's about trying to get into that kind of mindset. If we continue to treat the concept of PTSD as an illness, we will continue to talk about it in a medical way, and then when we talk to managers we are just fuelling the stigma and not necessarily helping them to manage their resources well, which is their prime concern.

Building a healthy first responder workplace

An independent review of mental health conducted for Victoria Police in 2016 found that protective factors in the workplace include work team level leadership support, well defined work priorities, having a say in implementing those priorities, a collegial learning-oriented environment which encourages debate and feedback around how the work is done, and a climate that validates wellbeing and early help-seeking behaviour as part of the way business is done. Hence a key organisational initiative in first responder organisations should be to increase 'people-focused leadership' with associated accountabilities at all levels in the organisation.[24]

Balancing the competing demands of the first responder environment

Developing 'people-focused leadership' can fall glibly off the tongue, but the first responder workplace is a complex environment. For example, ensuring that the workforce is as healthy as possible is not only an organisational capability issue, it also relates to the responsibility of the organisation's managers to the wider public. They have a duty to both staff and the public to ensure that, as far as is reasonably possible, they do not dispatch armed responders who are over-tired, acutely stressed, or psychologically impaired to dangerous or conflict situations, and that people in any of these states are not required to drive vehicles at high speeds or in circumstances requiring finely calibrated skills and judgment.

Important caveats around this obligation recognise the particular environment in which this takes place. It is not possible to 'get the organisational settings right' without marrying best practice to the circumstances in which people are required to operate. Hence, we have said 'as far as reasonably possible', because in urgent and life-threatening situations or in prolonged emergencies, managers may have few options, and they will not always be in a position to gauge the level of stress or fatigue that officers under their command may be suffering at a given time.

The evidence across the PTSD and operational stress landscape is still emerging, but it is clear that people react differently in different circumstances at different times and for different reasons. One size does not fit all and in an operational environment that is frequently time critical, spur of the moment judgments will sometimes need to be made. The organisational challenge is to ensure that operational managers and leaders are equipped with the best possible understanding of the reality of this complex landscape through ongoing in-service training, so that their decisions are as well informed as it is possible to make them. This commitment to equip people with the best possible knowledge and training is an important part of the implicit social contract between the organisation and its staff that, when operating well, strengthens capability. As one senior psychologist put it:

… if I come and work in this organisation and put my life on the line what are you going to do to look after me?...Ultimately it is not the actual work but it's about understanding and having the trust that the organisation is going to have your back if something happens. If you don't have that you can put as many education programs and policies and strategies in place as you like and they will not work.

Another aspect of this equation is the need to foster trust between operational staff and management. Front-line personnel need to know that senior management will deliver their side of this social contract when the chips are down. The social contract also needs to guide the development of policies, training, management and legislation.

ANYTHING WHICH CAN BE DONE TO INCREASE THE PERSONAL WELLBEING AND SAFETY OF FIELD OFFICERS AND IMPROVE THEIR SELF-CONFIDENCE IS TO BE SUPPORTED AND APPLAUDED. THE PUBLIC HAS AN EXPECTATION THAT POLICE WILL RUN TOWARDS DANGER AND POLICE AND OTHER FIRST RESPONDERS WILL ALMOST ALWAYS DO EXACTLY THAT. INDEED WE NEED THEM TO DO SO.

As a consequence, it is our responsibility to do all that is reasonably possible to ensure that the safest possible environment is created and maintained to accommodate this reality. This includes preventive and resilience training and education, management care and oversight, availability of counselling and medical care, effective rehabilitative options and pathways and, of course, effective and appropriate clothing and equipment that reflects the workplace in which field officers are expected to operate. The question "Who helps the helpers?" is a question police leaders need to be able to demonstrably answer.
Former AFP Commissioner Mick Palmer

24   Peter Cotton, "The role of workplace support in form of prevention and recovery".

People-focused leadership

While it is acknowledged that we are all ultimately responsible for our own wellbeing, it is also true that managers can have a large impact on the wellbeing of their staff and that they have a responsibility for ensuring the workplace is conducive to staff wellbeing. This point was reinforced by a participant who said:

I'd like to highlight to managers the importance of that relational aspect in prevention. Not just ticking the box but saying, for example, 'I know they've got kids at home similar in age to that child who's been critically injured or died' and checking with them to see how they're going. Often managers don't recognise how powerful that is. It makes a huge difference for staff.

A senior psychologist, referring to the literature on 'the protective factor of leadership' added:

[My organisation] takes it seriously, and it is almost intrusive because it is part of the culture that a leader does more than just turn up every day to the job. It's taking account of who their people are, what are they doing, and checking up on their welfare if they are on sick leave.

However, there was recognition in discussion that, however much the commander would like to assume people-focused responsibility, the pressures of operational circumstances can make this difficult. A participant added that those with first-class capabilities for running a command and control organisation might not necessarily be the best equipped for pastoral care:

You can talk about all the education and training in the world but not every leader should be helping someone who is not travelling well. We have some brilliant leaders in command and control but it doesn't have to be that person that someone needs to talk to. That is one of the stopping points — knowing that Mr Tough Love or Mr Command and Control is not going to get it. It's okay to say what we are good at and what we are not good at and to identify people in the workplace who are good to go to and we also have former police officers who could be mentors and confidant(e)s.

A related point was that people tend to get promoted on the basis of their technical skills, and may not have the requisite people skills for higher-level leadership. This was vividly illustrated by a participant who said:

I was in middle management — and if someone had come to me with a mental health condition I wouldn't have known what to do, and I'm not just talking about reaching out to officers who are off. Wouldn't have done it. It would be too difficult and I know I would get told to get stuffed. Didn't know how to manage the conversation, so didn't do it. I was very good at what I did technically but it didn't make me a good manager.

Managers may also lack the confidence to put their responsibilities to their people ahead of responsibilities to their organisation's business purpose. One senior police officer put it very bluntly:

Managers are not brave enough to say okay I have a business responsibility but more importantly I have a people responsibility. In emergency services where it is totally dependent on people, how stupid is that?

This could no doubt be remedied via an organisational culture that promotes and rewards managers' dual responsibility to not only complete the mission but also look after their people. The culture needs to give them confidence that decisions they make in balancing those responsibilities will be respected, and that if they put their hand up and say there is a problem, they too will be respected. Dealing with staff affected by traumatic stress puts a high expectation on managers' people skills and, according to one senior manager, not all are equipped to handle such sensitive situations:

Managers and leaders do have a critical role, but they're not going to be the absolute solution for everyone. Many of them are actually scared and frightened. I might be having a bad day and they won't know how to take my reaction. With the best intentions they might say something that will have an unintended consequence, and might make it worse. They have a fear and it's just as hard to address that fear as it is to address the fear of someone who is experiencing ill health and reaching out for help.

Supporting and training managers

Consequently, an important theme to emerge in discussion was the need to support not only the front-line staff but also their managers. Managers may genuinely desire to do the best by their impacted personnel but may not feel confident that they know how to do so. This can be remedied in part by training, but there is also a case for professional support when needed.

One participant shared their organisation's 8-year experience of providing mandatory management and supervision training for all managers and supervisors up to Commissioner level:

At the start we researched the issues and found that some of them didn't know they had a legislative responsibility for mental health as well as physical health. So some of it was giving them information about that.

They also didn't realise that the support was not only for staff but also for them. We had been really good at marketing to frontline staff but we hadn't marketed to managers. Since then, we have had a 350% increase in managers accessing support themselves. ...It has really shifted the culture around getting help. Managers were able to say to staff 'Hey I've accessed it and it's really helpful.'

So while it gave them information and education about what they can do to support their staff, it's also helped them value what it's like to look after themselves and access supports early.

A senior psychologist from another organisation described how they were working to build both the competence and the confidence of their managers in these areas:

We have been trying to up-skill our managers about early intervention and support ... focusing on developing both competence and confidence. So they have the skill to have the conversation and are confident to do so, and to handle whatever comes back. There is usually a lot of fear around that.

...We started a Manager Assist program a number of years ago, which is basically a phone consultation to the psychologists. ...Managers are putting their hands up and saying 'I've got this situation' and it might be the first sign that something's been noticed, or it might be to say 'I've done this and this and I decided to check', or 'This has happened and I have no idea how to handle it'.

That has created the opportunity to have repeated and continual involvement with the managers and to add ongoing education that is relevant to their daily experiences with their employees rather than that just being something didactic.

Subsequent to the Roundtable a world-first study was published in *The Lancet Psychiatry* which showed that basic mental health training for managers can reap significant benefits for workers' mental wellbeing. Led by researchers at the Black Dog Institute and UNSW Sydney, the randomised controlled trial considered the impact of a four-hour mental health training program delivered to managers from a first responder organisation. In addition to large reductions in work-related sickness absence, the training yielded a return on investment of $9.98 for each dollar spent. This is the first study to show that training managers about mental health can improve occupational outcomes for employees, and to calculate the dollar value of the intervention.[25]

While this study was not specific to PTSD, lead researcher at the Black Dog Institute, Associate Professor Samuel Harvey, noted that "These findings are particularly relevant for frontline emergency services workers, who face unique stressors throughout their daily duties that can potentially worsen or directly cause mental illness, such as post-traumatic stress disorder."

Mentoring

In this complex and demanding and necessarily hierarchical environment, formal mentoring was seen by a highly experienced former senior executive as an important support mechanism:

I think there is scope to have a proper mentoring system where people can hold hands on that journey. Having done 14 years mentoring all sorts of folk myself, what do I know about it? Your mentor is not necessarily your friend, but you do have to have trust; mentors have to be qualified and they also have to be helpful; and at the end of the day if the mentored are not getting benefit from the mentor then they should go find someone else. But I think that's an important opportunity to actually help people without spending a lot of money on it.

Basic supervision and operating procedure

While people-focused leadership is fundamental to achieving a healthy workplace, the nuts and bolts of management must also be addressed. This includes the workplace health and safety responsibility to operational personnel to identify and mitigate hazards peculiar to their workplace. One impacted officer said:

[Working as an unsworn officer] we had no standard operating procedure and didn't follow any OH&S regulations. Sometimes I spent 8 hours in front of a computer looking at these images and not taking breaks — and had no supervision. I ended up seeing over 5 million images related to victim identification in child protection in two and a half years, which is more than my team leader had in ten. So I think it's very important to have that supervision and to follow those basic procedures for your own safety. Management is very important. Looking back, I think doing those very basic things like taking breaks would have been very helpful.

Procedure should provide guidance and assistance not impose more stress, so it is important that post-incident procedures be conducted in a manner that fulfils their purpose without making matters worse for the front-line personnel involved in a confronting incident:

My biggest trauma after incidents is not so much with what is actually seen and what we've done, it's what pressures that managers place on us as a result of those particular traumas — say for instance, a death in custody. Those things have to be investigated, but if you don't know what is going on and what to expect it can make a stressful situation a whole lot worse.

We need changes to Standing Operational Procedures so that members are not affected by treatment from other officers who are there to investigate the matter. If we treated a member of the public in the same manner during an investigation we would be crucified in court.

25 Milligan-Saville, JS, Tan, L, Gayed, A, Barnes, C, Dobson, M, Bryant, MA,Christensen, H, Mykletun, A, Harvey, SB 2017, "Workplace mental health training for managers and its effect on sick leave in employees: a cluster randomised controlled trial", *The Lancet Psychiatry*, vol. 4, no. 11 pp 850-858, available at **http://www.thelancet.com/journals/lanpsy/article/PIIS2215-0366(17)30372-3/fulltext?elsca1=tlxpr**, accessed 20 April 2018.

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Organisational design as a health factor

Reiterating the impact of workload on ability to maintain or recover equilibrium (see Chapter 4), several participants noted the need to build down-time into organisational design 'so that you are rotating people through jobs that are stressful and they are getting that down-time, that ability to process what's happened and to get the support, which can be through the formal system or informally through peers.' A highly experienced former senior executive said:

If we accept that acute stress is a normal occupational hazard then we've got to design the structure of work to take account of that. People have to have time to recover from incidents and you can't have people on permanent call. You have to design the size of the work unit so people have a predictable stand down, so they know they're not going to get called this weekend — so they can have a life.

If you can't manage your workplace in such a way that your staff can take their leave at a time that pretty much suits them and their family, then I don't think you are managing your resources well. That might be a tougher call in policing, but I think we've got to have that kind of thought process.

Workplace culture and attitudes to mental health

A key contribution to people-oriented management is a workplace culture that includes a broadly held evidence-based understanding of mental stress. As one participant observed, there is a lot that can be done within agencies to provide an environment that encourages individuals to engage their own adaptive coping strategies and to access early interventions. This requires a shift in thinking away from the dominant pathological model toward a more holistic discourse that encourages multiple access pathways and multi-layered interventions — all of which are considered normal aspects of an individual's right and responsibility to ensure their own wellbeing. However, as one participant said, that approach can seem culturally foreign in a hierarchical structure:

We've been leading with the whole issue of shared responsibility which is a challenge because that means you've got to empower the individual, whether it's the client or whether it's the commander.

The cultural change needed by organisations can only be achieved by a significant commitment across senior leadership to develop and implement a mental health strategy that focuses not only on post-incident injury but also on increasing literacy and openness about mental health and reinforcing the joint responsibility between the organisation and the individual for maintaining their day to day wellbeing.

An experienced participant reinforced the importance of middle-level managers as custodians of the culture:

The cultural drivers of the whole organisation are the middle management — the Sergeants and the Senior Sergeants. Those blokes can make the biggest difference to an organisation, not your Assistant Commissioner and Deputy Commissioner. They can order things to happen but if the Sergeant doesn't agree with that he ain't going to make it happen, and the Senior Sergeant won't enforce it either. So if you've got good guys at that level who are willing to step forward and say 'Hey, I suffered from PTSD and this is what happened to me', it opens the door. It takes away all the backroom talk and the stigma about a bloke suffering from a mental illness.

A senior psychologist contrasted the emerging focus on wellbeing with the traditional approach of regarding PTSD as an illness. This shift requires a review of organisational policy frameworks to ensure that they are consistent with the new emphasis. A shift from 'illness' to 'wellbeing' will help to destigmatise PTSD and its precursors. Even the language of policy affects the way the issues are perceived:

While we spend a lot of time on the treatment, the real challenge is how you get organisational support. A recent example for us is that we are now at the point where we are reviewing all of the policies that we have written because we've written them on the basis of illness, we haven't written them on the basis of wellbeing.

Including matters to do with mental health in policy and procedure was seen as very important. There is a need for clear and declared processes regarding what will happen if people 'put their hand up'. It cannot be left to the vagaries of decision-making by individual managers: it needs to be a matter of a codified social contract between the organisation and its personnel. They need to know what the steps are, what their legitimate expectations are, including that they will be treated fairly, that they will be treated the same as everyone else in similar circumstances, and that if there is any criticism of their actions, performance or judgment, they will be accorded natural justice. As a participant said:

You normalise [mental health issues] by putting policy and procedure in place. If you have your trauma tracking, your safety net, if you have your support programs in place, people know what to do and it becomes normal, and if something is normal it's not a big stigma.

A senior police officer succinctly outlined the cultural end-state needed nationally with this mantra:

It is normal for the things we see and do to impact us; it is normal when we are so impacted to seek support or backup; it is normal with that support and backup to get better.

Conclusion

There is now good evidence on how to prepare people for working in trauma-related areas, how to manage and facilitate their healthy participation in the first responder workforce, and how to assist them back to health if they are injured. The issue now is to embody this evidence in the way first responder organisations are developed and managed. The internal efforts of first responder organisations are critical in this, but there is also a crucial requirement for broad community support and political acceptance of the need to resource first responder organisations to a level that enables them to fulfil their function while minimising the risk of injuring their workforce.

WHO RESCUES THE RESCUERS?

"If I come and work in this organisation, and put my life on the line, what are you going to do to look after me?"

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CHAPTER 6:
MAXIMISING WELLBEING FROM RECRUITMENT TO RETIREMENT

GOVERNMENTS, HEADS OF ORGANISATIONS AND MANAGERS OF INDIVIDUALS HAVE A RESPONSIBILITY TO MAKE THE MENTAL HEALTH OF THEIR WORKFORCE A PERSONAL TOP PRIORITY. HOWEVER, THESE PEOPLE ALONE CANNOT BE HELD RESPONSIBLE FOR EVERY EMPLOYEE'S HEALTH — PHYSICAL OR MENTAL. FIRST RESPONDERS MUST ALSO ACCEPT THAT RESPONSIBILITY THEMSELVES.

Heads up Good practice framework for mental health and wellbeing in first responder organisations[26]

Introduction

As Jeff Kennett, (then) Chair of *beyondblue* said, 'Our community needs the skilled support of every first responder it can get — and we need them to be mentally healthy and well.' Achieving this is a joint responsibility of the organisation and the individual.

To begin, it must be acknowledged that a number of protective factors for mental health and wellbeing are found in most first responder environments. The challenging nature of the work is likely to attract naturally resilient people. As well, the workplace culture for first responders is usually based around camaraderie and loyalty, and a strong sense of purpose in doing work that is highly valued by the community.

However, some of these protective factors may rebound if a person under stress feels unable to put their hand up for fear of letting down workmates or not living up to their own image of themselves as strong and able to cope. As well, the work includes repeated exposure to difficult situations and potentially traumatic events, which greatly increases the risk of developing a mental health injury or making an underlying issue worse. As graphically described in earlier chapters, operational stressors are part of the job. These include regularly working long hours on shift-work, being rostered to work at times others usually spend with family or friends, such as weekends, public holidays, birthdays and Christmas. This can have a significant impact on first responders' ability to access the support and interaction they need outside work, and can lead to social isolation and relationship difficulties that can pose a significant threat to a first responder's mental health.

This chapter draws on participant discussion about injecting a mental health focus at key points in the first responder journey from recruitment to retirement — unfortunately for some, a journey that will include experience of PTSD.

Recruitment screening and induction

Participants noted the dual responsibilities of first responder organisations in relation to recruitment and induction. This is not just about ensuring that selection criteria and processes identify the right people, it is also about ensuring that applicants fully understand what they are getting themselves into. Young applicants are likely to be attracted to the challenging and exciting elements of the job (solving crimes, fighting bushfires, rushing injured people to hospital, rescuing people injured in the bush) and to have less awareness of how confronting these situations can be.

Selection and screening also need to include understanding of the whole person and what motivated them to apply. As one very senior former police officer put it:

I think we could probably do more about pre-recruit screening and our selection processes. At least we should be alert to what people bring with them and make sure we are in the business of being able to manage it. They might be otherwise great people we want in the organisation, but we need to take them with an understanding of what they are coming with.

There was also agreement that it is important to brief families about what their sons, daughters, brothers, partners, parents are getting themselves into. This will better equip families to understand the pressures of the job and to provide emotional support in trying times. This would take place after selection and form part of an induction process. We believe that training programs need to include thorough explanation of what occupational stress is, what the likelihood is, and how personnel can recognise emerging signs in themselves.

It should be made clear at this stage that, because it's okay to seek help, every officer has a responsibility to speak up when they start to detect emerging signs in themselves or in their peers. This would have the benefit of changing the way this issue is viewed in first responder organisations from the outset.

Educating first responders about stress reactions and self care

According to a number of participants, it is not enough that psychologists understand the effects of stress on the brain. This information is empowering and needs to be in the toolkit of every first responder at all levels, and the information needs to be regularly updated and available throughout their career. As one impacted participant said:

We are now learning how trauma affects the brain and how we can learn to calm our nervous system. There is so much more that could be done in preparing first responders to go out to do the work they do and assisting them to know how trauma will sit in their bodies and how to deal with it before it overwhelms them.

Another added:

If we just say people in first response environments get PTSD because they're exposed to traumatic things, and don't explain the why factors about what's going on in their minds and bodies in the first place, then we have failed to give them the information they need to keep themselves as healthy as possible — and that is what we failed to do in the past.

We need to look at HPA axis[27] dysfunction and what that causes in a person's mind when they are stressed and sleep deprived. When you have these two combined and you're in an environment under pressure all the time, physiologically your body just can't cope.

When we talk to first responders about how the HPA axis functions and what happens when it doesn't work properly and becomes fatigued, they get it. They understand and they then know how to implement strategies themselves to address the stress reaction. They don't have to go to managers or anyone else. They can do it themselves, and the information empowers them and makes them stronger.

This was also supported by another experienced manager:

It's about normalising an acute stress reaction. If we talk about PTSD all the time that's what people expect they will get. If we normalise acute stress reactions and talk to them about the neuroscience people get the message 'Okay, this is it actually my brain doing exactly what it is designed to do and there are some things I can do to help me deal with that.' I often say to them this stress reaction is an indication that you are not a sociopath or a psychopath.

So we look to normalise — this is an abnormal reaction to an abnormal event and that's normal. It's about having education and information that is not pathology based, and to recognise that accessing a counsellor is about my looking after myself. It is not about having to reach breaking point before I go to see a counsellor. We now have members who just go for a mental health checkup, it's about them looking after themselves, their self-care. I tell them if you're travelling well yourself, you're able to give [the best service].

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26 "Heads up Good practice framework for mental health and wellbeing in first responder organisations", *beyondblue*, 2015. The introduction is also drawn from this document and the quote from Jeff Kennett comes from its Foreword.

27 The hypothalamic-pituitary-adrenal axis (HPA axis) is a complex set of direct influences and feedback interactions among three endocrine glands: the hypothalamus, the pituitary gland (a pea-shaped structure located below the thalamus), and the adrenal glands. These organs and their interactions constitute the HPA axis, a major neuroendocrine system that controls reactions to stress and regulates many body processes, including digestion, the immune system, mood and emotions, sexuality, and energy storage and expenditure.

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Involvement of families

While families are not trained in mental health they are often the frontline support for psychologically injured first responders. Several people at the Roundtable spoke about the benefits of educating families about workplace traumatic stress and involving them not only at induction but at critical points in the first responder's lifecycle. If the general benefits of providing opportunities to involve families are accepted, policy and procedure need to be developed to facilitate this. Beyond being clear about the aims and boundaries of such a policy, issues such as using language that is meaningful to the families need to be addressed. A participant from a support services background said:

The language of what first responders do is understood when you're in the job, but it is a world of acronyms and what does that mean at home? I think education is important and explaining the language helps break down the stigma and increases mental health literacy and just opens up conversation. Anyone who is in our world needs the education to understand what we trying to do and how they can help.

A senior psychologist added that this issue can be complicated:

It can be difficult to involve the families when the [serving member concerned] is the gateway and they don't want family to be involved. Breaking through that barrier is something we are looking to grapple with as well.

In our view, it would be helpful to have clear protocols about involvement of families including what first responders can discuss with their families — not the specifics of cases, but enough in general terms to enable them to have a meaningful discussion of what they are dealing with.

The importance of managers

Relationships with manager and managerial performance are important aspects of the workplace journey. The need for managers and supervisors to be trained in people management and in understanding the impacts of workplace stress is critical in first responder organizations. All of the issues raised in the discussion about leadership and supporting managers in Chapter 5 apply here.

Trauma tracking and wellness checks throughout first responders' careers

Throughout their career, first responders are inevitably exposed to trauma. A participant suggested that a system to track exposure to cumulative trauma is needed to identify officers with a high level of exposure as a matter of routine, so their specific needs can be assessed and timely treatment offered if required.[28] The routine nature of this intervention would help to reduce stigma. We understand that such a system is being tested by the police organisations in NSW and Victoria. Victoria has implemented Safe-T-net, an electronic monitoring system. Its primary purpose is to facilitate conversations between managers/supervisors and their staff following incidents.

An individual's experience cannot always be predicted by the number of incidents, so tracking of incidents will not necessarily result in accurate identification of individuals who are showing signs of mental ill health. However, the system can be routinely used to prompt managers to speak to their people regularly about the impact of the incidents they face, with a level of accountability within the system. Victoria Police is both tracking incidents and also developing managers. If the outcome is beneficial, this initiative could be widely shared across first responder organisations.

A stepped care approach is needed, which meets the needs of the individual at the level they are at — providing those who are symptom-free with education/awareness, implementing support mechanisms for those who may experience a reaction to an event, and providing appropriate clinical treatment and care for those experiencing mental illness. Monitoring needs to follow the same path, using different avenues and methods people can connect with.

Similarly a self-initiated 'well check' mentioned at the Roundtable, whereby officers exposed to trauma initiate contact with a psychologist from time to time to check on their wellbeing even if they feel they are symptom free, is an initiative that could be widely adopted.

Compassion towards impacted personnel

An impacted person commented on his personal return to work experience that it is the immediate team leader and supervisors who really need the education and information, and how some managers don't know how to handle conversations with personnel returning to work:

I had a team leader who hardly spoke to me for eight months because I had to change my shift so I could get intensive cognitive therapy. And when he did speak to me every single time it was 'How is your mental health?' If I raised a concern about work practices or something he just said 'Has this got anything to do with your mental health?'

Several participants had experienced or observed a lack of compassion towards those who were under severe stress. This may reflect lack of appropriate training for people rising up the supervisory ladder in how to handle inter-personal relations in these circumstances. Be that as it may, one participant commented:

I would like to see more compassion in our first responder organisations. Sometimes our organisation feels inundated by members of the [first responder organisation] who are suffering. They come to us with PTSD, with anxiety, with depression, with all levels of stress — and a lot of it has come because there is a lack of compassion out there. There is no compassion for those people.

After [a recent suicide] a lot of ex-members contacted me, they wanted to talk about their experiences and they are still very angry. They are all still suffering from some level of PTSD and it wasn't the incident itself so much as how they were treated afterwards. It was the lack of compassion for what they were going through. That is something that comes up from our members all the time — the lack of compassion and the callous decisions that are made — that's what creates the problems as much as the trauma itself.

Supporting 'survivors'

The above quote suggests that the emotional wellbeing of a workplace team needs to be considered when mental health issues arise for one of its members. For example, workmates may react with feelings of self-blame or guilt for not identifying the issues earlier and providing support, they may experience un-discussable anger and resentment associated with managing additional workload caused by their colleague's absence, and they may experience fears about their own mental health and whether they will be next.

Peer support

Several participants agreed that peer support, while more informal than the prevention and assistance programs provided by the organisation, has a useful role in the overall mental health and wellbeing support system.

You can have more honest conversations with peers and get more support, which I think is very important in these sorts of organisations where relationships with your peers are crucial.

It was also suggested that a pool of retired first responders in some jurisdictions would be keen to fill a peer support role for currently serving members, with the advantages and disadvantages of not being part of the current system.

In Victoria, the Retired Peer Support Officer Program was created in 2014 by the then Vice President of the Retired Police Association of Victoria. All of the Retired Peer Support Officers are volunteers and trained Peer Support Officers. The program is supported with existing internal services of Victoria Police and is becoming a more established service to support former police.

Personnel on leave

Both the voices of lived experience and the contributions of managers and support personnel indicated that clear protocols about maintaining contact with impacted personnel while they are out of the workplace are needed — but only to the extent that is helpful. Several impacted personnel referred to not being contacted, and a senior manager with a police organisation reported having received frequent comments to that effect. On the other hand, no one suffering this impact wants to be intruded upon by someone they feel is just going through the motions. As the senior manager commented, this suggests the impacted personnel needs to have a measure of control over this process:

So let's recognise that Commander X may not be the person to make the call. Let's give control to the person and empower them and say 'Who are three people who would be okay to call you?' And if you say to us 'I never want to hear from you' we need to record that and be really upfront about that.

Return to work

There is increasing recognition of the importance of work for individual wellbeing and recovery from mental illness. Beyond its financial benefits, work can give daily structure, a sense of worth and regular supportive social engagement, however this may require a change of mindset. For many impacted personnel return to work (RTW) needs to be seen as part of the recovery process, not something that happens subsequent to it.

The paradox for first responders affected by PTSD is that the positive impact of return to work in a familiar environment carries with it the risk of exposure to triggers they wish to avoid and potentially to further trauma. As described later in this report, modified work roles for first responders returning to work while recovering from PTSD may be required. From the point of view of aiding recovery, it is important to find the best job for the returnee rather than just fitting them into an available slot. If this means tailoring of a position to suit the individual, we suggest this is a step worth considering.

28 Shoebridge, D 2014, "Police Psychological Injuries A Roadmap for Reform", *Parliamentary Forum on Police Psychological Injuries.*

However it is not just a matter of organisational willingness. Managers need to work with the individual and in partnership with healthcare professionals and others involved to achieve the best outcomes. Along with offering alternative duties, specific work-focused interventions may be needed along with symptomatic treatment because experience suggests that standard symptom-focused treatments do not necessarily lead to acceptable occupational function. While RTW is a critical stage in recovery, there is an evidence gap in this important area as most of the available literature looks at reduction of symptoms of PTSD, and relatively few trials consider occupational function as a primary outcome.[29]

Participants agreed that RTW is a very important and sensitive stage in recovery and that policy and creative thinking around options need to be improved. A senior police psychologist said:

… I think in many ways we still focus on the physical criteria to return to work rather than looking at what does return to work look like from a psychological capacity point of view. What are the psychological skills people need in their work and how do we reframe that return to work in terms of their psychological capacity rather than some of the physical limitations?

Even when a person is deemed ready to RTW after the best and most effective treatment, if the process is mismanaged and/or the workplace is unsupportive, the person's journey to recovery may be unnecessarily prolonged. However, RTW is not just about willingness of the workplace to accept people back, and the readiness of the individual to return; systems issues need to be addressed to facilitate better outcomes.

Some systems issues stem from changes pursuant to the drive for greater efficiency. Front-line personnel have been carefully selected and are highly trained, so prima facie it seems wasteful to have them do work that can be performed by others. However, this is perhaps too narrow a view — a more holistic view would have regard to the operational tempo that is sustainable for front-line staff without causing them avoidable damage.

Several participants commented on this issue from different perspectives. One participant from a Police Association said:

There is the really big push for everyone to be operational. You must be able to carry a firearm with the terrorism threat and so on. We are injuring more people than we can put back into non-operational roles so we've got a group of members there we're trying to get back to work but there is no real place for them, so what happens to them? That leads to some real conflict between the union and the force and what's in the best interests of getting the person back to work. That is a real system issue. Can we create alternative duties for these folks to do that are not operational when the force is getting hammered because crime rates are going up and we need more coppers on the street etc.? What do we do about these members who are injured and can't get into the workplace if they don't get back to full operational capacity?

One very senior police officer said:

Policing has changed and we are allowing functions of policing such as custody issues to move away from police officers, so that does take away the roles that non-operational police officers typically could have gone into. And it's not only there, roles have gone in administration areas that police used to do because there wasn't anyone else.

It doesn't make sense to use police in those roles where you don't need that highly expensive skill set, but we do need to have some RTW options. I think the argument is that everyone is turned off because we say police don't do that anymore but who is saying that's the case? Saying police don't do those roles typically isn't saying you can't go temporarily into those roles for relief. I think there is a closing down of discussion here and it needs to open up.

Another senior police participant said:

About return to work, Vic police has gone on a series of tours around the state to bring local GPs, psychiatrists and psychologists into a session with the local management team. One of the fundamental things we talk about is return to work options within the local policing area, because what we found is that the GPs and psychologists and so on all think policing is what they see on TV. They think that is it. Management team on the other hand think we can't make work for them temporarily. It's about educating them together so they'll come together and have a conversation to find return to work options. Now this isn't a permanent fix, it is not creating roles, but we are talking about relief and transition. As part of the Victoria police new resourcing model we've got resources to replace maternity leave which we never had before, we've got resources to take people away from the front line, so it comes back again to building up that base level.

There is also the policy question of operational pay if a person returns to work on non-operational duties, as this can have significant financial impact. A Police Association participant commented:

I wanted to raise return to work issues because that's what a lot of our members come to the union about — reintegration into the workplace after they've been diagnosed with mental health issues. And the AFP has a paystream related to operational and nonoperational roles. Some of these people have been in an operational role and they come back to a nonoperational role, so that not only are they unwell but they appear to be punished by losing their 22% operational payment. That is an issue that is quite significant for many people we see at the Union and it is something that needs to be addressed. On top of being unwell they also feel that they are being financially punished. Unless they have an accepted worker's compensation claim they are suffering financially as well and it stops them coming forward, and that also brings up the stigma issue.

Transition and post retirement support

There was discussion about managing transition out of the service in a healthy way, given that the service has been a source of identity and cultural support beyond the level of most workplaces and for many people over a number of years. Connecting with retired members and offering support as required was also raised. A participant from a police support services background commented:

We celebrate people becoming first responders, we have ceremonies, we develop them throughout their career, we celebrate their achievements. If they get unwell during their career and leave not only are they dealing with post-traumatic stress, anxiety or depression, they have also lost their identity — and I can't even imagine the right words for the grief around that. So let's also look at the post service point of as well. Being prepared is really important, but let's celebrate people leaving, let's celebrate what people have done, let's get people together and say thank you.

Another aspect of the transition journey for those who have been injured is the cost of treatment, as expressed by a support worker:

There is also an issue with the cost of programs. Some of these programs are brilliant, but the cost is out of control. '… I am transitioning out and I've got a husband and three children at home and it's going to cost me $1000 a day to get 16 days in a hospital or to get the treatment I need so I don't go home and kill myself.' Who can afford that? So it's all great, we talk about these fantastic programs, but at the end of the day these programs cost a lot of money and a normal person who is transitioning out and needs assistance does not have the funds to do that. Where do they get that money from? Who will fund these fantastic programs that we can't tap into?

We were amazed to hear comments to the effect that individual families are footing the bill for treatment for injuries acquired in the line of duty. In our view an essential component of the 'if I put my life on the line for you what are you going to do for me' social contract between the first responder and his/her organisation is that compensation arrangements are set up in such a manner that the costs of treatment will be borne either by the employer or by the workers' compensation insurer.

A comparison was made with the situation for military retirees who have access to a range of support services through the Department of Veterans' Affairs (DVA). A very senior police participant said:

I'd like to raise the DVA piece for emergency services. Emergency services officers serve too and yet when you're ex emergency services you're just ex. How does society allow service by the military to be recognised in this way and yet fail to recognise first responders? To have a whole group of people across this country who serve every day of the week in environments just as risky, who sacrifice their lives, who sacrifice their quality of life, who sacrifice their health, who sacrifice their family relationships — and then say at the end of that, there's nothing. What is wrong with us?

Given the high-risk environment in which many first responders have spent their working lives, the issue of post-retirement support, particularly for the current generation of retired first responders who may not have benefited from the treatment and policy options now available, is one that should not be overlooked.

Conclusion

The workplace and the working life of the first responder is uniquely challenging and uniquely rewarding. From recruitment to retirement and beyond, initiatives can be taken to encourage self care, to ensure organisational processes facilitate good mental health, and thus to lessen the risk that exposure to potentially traumatic events will negatively impact the mental health and wellbeing of first responders during their employment and retirement.

While this is only one part of the overall picture of preventing PTSD and enabling wellbeing, there are clearly opportunities to improve practice at managing the employee lifecycle which could have very positive impacts for both the organisation and those who work within it.

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[29] The first two paragraphs in this section are drawn from material provided by Dean Yates.

IT'S ABOUT NORMALISING AN ACUTE STRESS REACTION

If we talk to people about the neuroscience they get the message 'Okay, this is it actually my brain doing exactly what it is designed to do and there are some things I can do to help me deal with that.'

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CHAPTER 7:
ACCESSING THE RIGHT CARE — ISSUES AND CHALLENGES

WE SHOULD BE TALKING ABOUT A SPECTRUM OF CARE FROM COMPLETE PROACTIVITY AND PREVENTION THROUGH TO INTERVENTION SHOULD ALL OF THAT FAIL.

A Roundtable participant

Introduction

There is no denying that the work environment of first responders exposes them to traumatic stress. Because the special nature of first responder work means that some people will become psychologically injured, organisations need to develop specific strategies to maintain and, if necessary, restore mental health and wellbeing.

Many organisations represented at the Roundtable have implemented approaches to accessing mental health care, which are yielding positive results. This chapter largely draws on their experience, with the intention of identifying some principles and practices that could be usefully applied across the nation.

There has been a great deal of progress in both organisational management and treatment options in recent years, as one participant illustrated:

I experienced PTSD in the early 90s and the treatment regime then was one hour with a psychologist, 55 minutes of that was me explaining how my service worked, five minutes was advice and please sign here so he could get his money. That was it and then you were sent on your way. So we've come an enormously long way, and I wanted to recognise everyone for that.

The commitment from all participants at the Roundtable to take advantage of new knowledge and keep this progress happening was tangible and encouraging.

Including the potential for post-traumatic growth from the start

The concept of post-traumatic growth was raised by several participants, so it seems beneficial to introduce this concept in framing an organisational approach to mental health. An experienced senior manager said:

Despite the research on resilience and post-traumatic growth (PTG) the dominant discourse for many first responder agencies is based upon a purely pathological view of exposure to trauma. Whilst this might help provide discourse around trauma, it is only part of the picture. We do need to acknowledge that some individuals may be psychologically injured and will suffer from PTSD given the nature of first responder work, however we also know that many more, given the right environment, information and interventions, are likely to remain well.

Research to support this approach was provided in writing by a participant:

Significant research into experiences of potentially traumatic events within multiple other traumatic contexts (Tedeschi and Calhoun, Shakespeare-Finch, Bonanno etc.) has demonstrated statistically high levels of PTG and resilience and low levels of burnout and secondary traumatic stress (Shakespeare-Finch). This research has informed a Salutogenic[30] approach to trauma education within [my organisation] predicting that personnel are more likely to experience resilience and growth than pathology. This education provides individuals with an understanding that an acute stress reaction to a potentially traumatic event is considered normal and necessary for PTG to occur.

The critical factor being, what adaptive coping strategies the individual adopts after the incident in terms of openness to accessing support. The Salutogenic approach assists in reducing stigma around seeking help and reduces anxiety for individuals as the focus is on wellbeing not pathology. For many individuals beginning their career with [us], it is a significant relief to be told that PTSD is not an inevitable outcome of experiencing trauma. [We] provide consistent education across all areas of the organisation which focuses on maintaining wellbeing and includes PTG, resilience and adaptive coping strategies.

Providing the knowledge and tools to encourage mental health wellbeing

Organisations should ensure that people are equipped with the knowledge they need, particularly the neuroscience of stress reactions, described in more detail in Chapter 6.

Understanding the neuroscience of stress leads to emphasis on the importance of calming techniques. While mindfulness is usually not recommended in the acute stages of a mental health episode, it appears to have benefit as a preventative measure as described below and, as reported by several participants, in the recovery phase. Subsequent to the Roundtable, the authors became aware of specially designed mindful policing initiatives in the US and Canada aimed at reducing stress, increasing resilience and enhancing officers' capacity to respond effectively to threatening situations. The goal is practical: 'It's not about going to your happy place. This is not la-la lightweight nonsense … This is blood and guts, sometimes life and death.' Research on outcomes now being conducted may be profitably monitored for Australian first responder organisations.[31]

Individuals are different — for many, calming can come through mindfulness, for others it may be sport or music or horse riding or art, others may like to monitor their reactions via smart wearable technology as it becomes available. The issue for organisations is to sanction the validity and benefits of personal calming mechanisms for first responders exposed to regular traumatic stress.

Establishing a 'spectrum of care'

The consistent message from the Roundtable was that a whole-of-system approach is needed if we are to prevent PTSD and, should that fail, to provide the best possible recovery options. While this chapter will talk about diagnosis and treatment, as described by a senior medical executive the spectrum of care is broader than the medical model:

Mental health is part of the holistic spectrum of understanding the person, and we need to think about mental health itself as a continuum. One of the things I'm struck by looking across first responder organisations is that the conversation is dichotomous — you are either well or you are mentally not well. And the reality is that's not the case. We are all on a continuum around mental health and we all fluctuate on it on a daily basis. A critical part of dealing with stigma is moving this conversation away from this dichotomous approach. Given that it is a continuum, what does intervention look like, what does support look like all along that continuum?

Organisations can integrate population health strategies with the employee lifecycle approach to health to provide for a holistic and comprehensive model for staff mental health and physical health.

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[30] Salutogenesis is a term coined by Aaron Antonovsky, a professor of medical sociology. The term describes an approach focusing on factors that support human health and wellbeing, rather than on factors that cause disease (pathogenesis).

[31] Yeoman, B 2017, "Mindful Policing: The Future of Force" *Mindful*, **https://www.mindful.org/mindful-policing-the-future-of-force/** accessed 10–7–2017.

Other comments were made on the importance of strengths-based principles for mental health strategy in first responder organisations:

It is important to use what works for people recognising what their strengths are and how we can leverage more of those strengths. Sometimes just focusing on the problem only makes us experts on the problem and doesn't always lead to the right solution.

and on the need for clear, universally understood messaging:

If we are thinking about what the intervention spectrum looks like we should try to use the same language so that we are building up the intensity of what we are talking about and people understand the underlying principles.

Giving agency to first responders

At the centre of a strengths-based 'spectrum of care' ranging from proactivity to intervention is the individual, with all the experiences and attributes the person brings to the job. Consequently, an essential component in designing and delivering a spectrum of care is the voice of lived experience. However, it is not enough to hear the voices of consumers as story tellers and role models, they need to be closely involved alongside management and professionals in deciding how services are designed and delivered. Commenting on this, a senior medical executive said:

The accreditation standards for general mental health include the level of consumer participation in the management and operation of the service. So they have consumer advisory groups and the practical issues, which often don't get addressed if you have a service just run by health professionals or managers, get addressed that way. So you are looking at the structural systems rather than just having a reference group occasionally. You've got a regularly meeting group that goes through your strategic plan, your monthly operating decisions about contractors and systems. This can put control back to the service user. I think personal control and consumer participation at all levels can help overcome obstacles and overcome stigma in the way our systems are designed.

Another important aspect of participation involves providing the information necessary for first responders to have agency in their personal treatment choices. A highly experienced senior medical executive said:

We need to recognise the fundamental importance of personal control and choice in terms of the treatment and therapy. People want and need to be informed about what the evidence base is of the range of therapies. There [are] actually a number of therapies and treatments and, depending on your personal experiences, your circumstances and your beliefs, you might choose one sort of therapy over another, you might match up with one therapist or another, or have different views about what the threshold is before you would consider taking medication.

So control and choice are fundamental and if people have the condition where loss of control in their own emotional reactions is part of the illness, let's design the health system that gives people as much control as possible about where they go, who they see, and what they do. In the broader world with programs like the NDIS, the consumer actually has a strong voice in how the funds allocated to their treatment and care are spent.

Getting help is not straightforward

Even with the best organisational management and with sound mental health strategies in place, some people will still become injured and need treatment to help them deal with PTSD. Stories of lived experience reveal how difficult it is for many first responders to access the help they need:

When you're in trouble and you're looking and you don't have anyone to assist you, you get onto the web and you pop in PTSD — and there is so much there. If you're not coping mentally how do you choose what's the best treatment for you? It's very personalised and a whole other conversation but I think there is a concern about the different avenues you can go to. We do have Lifeline and beyondblue, but if you don't know it you don't know where to look. ... Organisations that have websites need to tidy them up to make it easier for people so they know what to pick.

Before or after web searching, a person seeking help will often speak with their manager or supervisor, however participants related stories which indicated that many managers had been, and felt, ill-equipped to deal effectively with this conversation. Positive change at senior levels was noted and commended, but as expressed by one participant there was still some way to go at middle management level:

I disclosed to an acting Deputy and Assistant Commissioner and the Commissioner and they were all exceptionally supportive. I can't begin to tell you what a difference that made to my mindset to know I had that support. You have got to have that buy in from the very senior folk, but it's got to trickle down and in my experience that's the problem that we have — it is not getting through to the first and middle tier of leaders — and that is where we've got to change the attitude.

The failure of middle managers to emulate the supportive behaviour of senior managers was identified by several participants as an important issue.

Once a person has raised their hand, the next port of call — either via a manager's recommendation or self-referral — may be the organisation's Employee Assistance Program (EAP). Unfortunately, as described below, this first step does not always elicit a useful response from the professionals who should be there to help.

Difficulty and variability of diagnosis

There was consensus among participants that it is unproductive to look at diagnosis as a straightforward process and to view treatment, even if the person is fortunate enough to access a trained and competent therapist, as a lock-step solution. According to one doctor experienced in this field there is significant variability in how the diagnosis is made. The first contact is often with GPs, who frequently lack the skills or expertise to appropriately diagnose PTSD or may not be across best practice in this area, so there can be gap in getting to the right treatment for the right illness This can flow on to referrals for treatment. PTSD can also be over-diagnosed by medical professionals who are also poor at differentiating industrial from clinical issues. Police officers with any mental health problem can be diagnosed as having PTSD, and, paradoxically, these loose diagnoses can lead to under-diagnosis of those who actually do have PTSD, as described in the following:

Workplace conflict, perceived poor management, are common threads in those who present for assessment. Issues such as general dissatisfaction with their job, unresolved conflict with management, underperformance at work, outstanding disciplinary matters, etc. have a significant impact on the members' motivation to seek out treatment and obtain remission. In my personal experience of dealing with members with PTSD, a significant proportion of members have secondary gains as a claimable WorkCover diagnosis.

As a result, a diagnosis of PTSD may lose its credibility among the police community. The stigma that PTSD is not 'genuine' can result in officers with the condition avoiding disclosure or treatment, so PTSD can also be under-diagnosed because of that stigma.

Another medical practitioner added:

It is also important to recognise that PTSD can be a really difficult diagnosis. By the time it is diagnosed there is likely to be workplace conflict but workplace conflict does not mean someone has PTSD, and just because they have PTSD doesn't mean they should be performance managed.

Given these complexities, the following comment made about external providers by a senior psychologist in one of the first responder organisations is perhaps not surprising:

We see some really dire assessment work, it's disgraceful. We know that we have a lot of people with a misdiagnosis who were receiving the wrong treatment for the wrong issue. So is it any surprise that we are not seeing better recovery rates? And that's across doctors, psychiatrists, psychologists, the range of people who are diagnosing PTSD and other mental health issues who really shouldn't be.

There is also need for considerable improvement in strengthening the trust and working relationships between organisations and those providing assistance either internally or externally, as a participant said:

While at the senior level we've got people saying please raise your hand, the thing that's missing is trust — and trust in the system. I don't just mean individuals who are serving members, it's the trust of the providers. Some of those providers don't trust the organisation to protect the employees so they play the role of protector themselves. That leads a number of them to say 'he does need six months off and I will write down PTSD'.

Accessing evidence-based treatment is not assured

While the EAP is often put forward as a gateway to assistance for first responders, there was considerable disquiet among participants about the efficacy of employee assistance programs. It became clear that there are various models operating in first responder organisations with varying standards of service.

Some programs are in-house; some are externally provided. Some are staffed by counsellors highly trained in PTSD treatments; some are staffed by generalist counsellors without specific skills in PTSD. Some offer face-to-face counselling with no limit on sessions, others may limit the number of face-to-face sessions, and some provide a phone-in service without continuity of contact. One person rang into an EAP in distress and was told to ring Lifeline. A general concern was that counsellors may not be trained in evidence-based trauma therapy. Most concern was directed at the phone-in services. Given the difficulties many first responders have in asking for help in the first place, and the complexities of treating PTSD, a poor response at first contact is a wasted opportunity and has the potential to exacerbate the stress and distress of psychologically injured first responders.

Much of the adverse commentary was directed to outsourced EAPs. This was countered by one participant who said that an outsourced EAP works well if the organisation specifies the contract correctly. The organisation has to pay attention to what it needs and construct the contract accordingly — and be prepared to pay for the requisite quality of service.

A Defence participant commented that Defence doesn't have an EAP. If an ADF member is starting to struggle, that becomes a matter for their immediate commander and their CO. This is an alternative model that we think worthy of consideration.

We suggest it would be useful for a representative group of first responder organisations, made up of senior leaders and medical and psychological professionals, to engage with the Australian Medical Association and the Australian Psychological Society to seek solutions to this problem.

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Treatment standards vary

The situation in the helping professions is not a great deal better than in the EAPs. Poor clinical practice is found among many treaters. A medical practitioner said:

We see significant variability of treatment of PTSD. This can be due to the health professional not recommending evidence-based treatment, the individual not willing to undertake appropriate treatment or the individual receiving poor advice from colleagues, friends, or others. A proportion may receive no treatment at all, other than avoidance of the workplace.

Another experienced heath professional added:

I'm a senior sessional mental health clinician with [a regulatory organisation]. We do peer-to-peer contact, talking to treaters about what they're actually doing and we talk to more than 950 a year. What strikes me is the enormous variability in what goes on out there. At least 50% of psychologists are not up to the job of providing competent PTSD treatment. At least 50%. That's pretty shocking. We need to establish networks of specialist PTSD assessors and treaters whose practice is consistent with Black Dog Guidelines and the Australian Health Benefits of Work agenda.

The recommendation in guidelines published by Phoenix Australia is clear — 'Practitioners who provide mental health care to emergency workers with PTSD, regardless of professional background, must be appropriately trained to ensure adequate knowledge and competencies to deliver the recommended treatments. This requires specialist training, over and above basic mental health or counselling qualifications.'[32] According to the expert and experienced voices at the Roundtable, these guidelines are not universally applied. This is a serious breakdown in the system of care with severe consequences for PTSD-affected first responders.

A senior manager said:

We are trying to do much in our organisations, much with our people, much with our culture, much with our leaders, but when we deal with groups of doctors — it's not all of them — who will refuse flatly to even consider the application of the best treatments for our people, and what we know is that this makes our people sicker, and they are discharged, they don't get better when they are discharged, they get worse, then this is a big issue that somehow at government level or otherwise needs to be addressed. This is the biggest issue.

This issue was summed up by a highly experienced senior manager:

There's lots of variability across the organisations in the level of confidence about what's being delivered. We should be able to hold our hand on our heart and know that they are getting the best treatment available. The building up of the contracting and quality assurance space, whether internal or external, is needed so when the folks who go through all of the pain and suffering put up their hand we're confident that in that window of opportunity we are offering the very best that we can for them.

A logical conclusion from the evidence presented on this issue is that improving contract specification and contract management of providers would improve the experience of first responders seeking help. A number of practice standards have been developed including Phoenix Australia's 'Australian guidelines for the treatment of acute stress disorder and post-traumatic stress 'disorder', Black Dog Institute's '*Expert guidelines: The diagnosis and treatment of post-traumatic stress disorder in emergency service workers*' and '*A national framework for recovery-oriented mental health service guide for practitioners and providers*' prepared by the Australian Health Ministers' Advisory Council. However, they are not being used to guide practice. Significant work needs to be done — perhaps via the professional societies — to encourage/mandate the use of evidence-based treatments by medical officers and counsellors.

Complexities of providing treatment, even when evidence-based

Treatment knowledge about PTSD is continually evolving. For example there is growing awareness that PTSD may not be a single homogeneous entity but may have subtypes such as fear/avoidance and a depressive/misery type, which are likely to respond better to specifically tailored treatments. There is also growing recognition of the importance of moral injury in PTSD. Further research in neuroscience is likely to yield new insights and methods of treatment. Currently, the recognised gold standards for evidence-based PTSD treatments are Trauma Focused Cognitive Behavioral Therapy and Eye Movement Desensitisation and Reprocessing.[33]

Therapists in the room pointed out that while using evidence-based treatments is fundamental, they are not the answer for everyone and the complexities of the therapeutic relationship and the person's circumstances will also affect the success of the intervention:

With the evidence-based treatment it isn't just a matter of you've got a broken leg, so I'll put a splint on it. It is a relationship. The person comes in with history and beliefs or all sorts of expectations that can either be beneficial in establishing a relationship or put a whole lot of barriers in the way because they don't trust you, they don't trust the organisation, and there's a lot of reasons they want to keep that PTSD diagnosis alive and well. The treatment is one part of this puzzle, but the person comes as a whole person, in the organisational setting, the family, the community — that person comes with a lot of baggage. So that trust is really important and that's where some of the research in neuroscience is saying that rather than using cognitive behavioural therapy alone which is a top down approach we actually need to focus bottom up. The person will not really engage with a therapist or with anyone unless they trust you.

Another therapist added that timing of intervention also influences outcomes:

I am absolutely not going to begin evidence-based treatment of trauma when someone is at that acute care point of transitioning out — losing their identity, worrying about their compensation, whether they are going to get paid, and whether they are going to be able to keep the family home. I am not going to be able to undertake this really heavy duty trauma treatment when their whole life is changing around them. So I really wanted to acknowledge that difficult transition point and the additional complexities that it brings to trauma treatment, regardless of the evidence base.

Adjunct therapies can be helpful

Many participants, including professional therapists, acknowledged the important contribution of adjunct therapies. One participant described a creative arts and trauma program for serving members that used writing, music, visual arts and drama to assist recovery from post-traumatic stress and other stress disorders, which has received very positive feedback.[34] This group is also looking at and will research the use of augmented reality:

One of the areas we are looking at is emerging technology with hollow lens augmented reality and we getting some really positive results from [members] who are starting to use visualisation and narrative to look forward in their lives rather than looking back — drawing a line in the sand and saying 'This is who I am now and this is what I've done, but also how do I visualise myself and my environment in three hours, or in 3 weeks, in three years or in 30 years?' So rather than continually revisiting their trauma they are actually moving forward.

A practitioner added:

Anything that brings people back into the moment and stops the rumination into the past can yield results whether it be art therapy or [animal] therapy or whatever. It is bringing people back into the moment and starting to break that cycle so they do not keep going over and over the trauma. So I think those sorts of therapies can have a place. It is about being human and being able to tap into what it is that makes you yourself. Often I hear 'I just want to be my old kick arse self.' A lot of first responders want to go back to that, but the old kick arse self is not there anymore, we need to go forward, and find our joy in what those new things are.

A senior psychologist concluded:

While these kinds of therapies may seem bizarre there is actually a randomised control trial of arts therapy in cognitive processing therapy, one of the gold standard therapies for combat-related PTSD. It was only a small sample, but they found it did improve trauma processing and veterans found it to be an important part of their treatment. A lot of what we call adjunct therapies work really well along with some of the evidence-based therapies for PTSD and all the other mental health conditions. The contribution of neuroscience is showing that things like music and art help people to regulate the HPA axis and it is important that we understand more of the why and how these adjunct therapies work.

32 Phoenix Australia, Centre for Posttraumatic Mental Health, 2015 "Expert Guidelines: Diagnosis and Treatment of Post-Traumatic Stress Disorder in Emergency Service Workers".

33 David Forbes, Andrea Phelps, Jane Nursey and John Coper, "Navigating a path to more effective treatment".

34 See Defence ARRTS (Arts for Recovery Resilience Teamwork and Skills) at the University of Canberra **https://www.canberra.edu.au/research/faculty-research-centres/cccr/research-projects/creative-arts-and-trauma** accessed 4 April 2018.

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Although the evidence base for use of the arts in dealing with the aftermath of trauma is still emerging, there are some compelling practice examples.[35] A recent review of research in this area found that the practice of art therapy with some patients diagnosed with PTSD could help them to express thoughts previously unable to be verbalised, improve social relationships and reduce social detachment, and lessen the symptom clusters around re-experiencing, hyper-vigilance and avoidance/emotional numbing.[36]

People who are refractory to current treatments

Even if a person has access to the right treatment at the right time, the elephant in the room when talking about treatment is the research that shows 30–40% of people presenting with PTSD symptoms do not respond to the treatments offered. There is an urgent need for more research in this area.

The fact that such a large proportion of people presenting with PTSD symptoms are unable to be brought back to health on the basis of current knowledge and practice only serves to emphasise the importance of minimising the risk to first responder personnel, by measures such as controlling exposure, identifying as early as possible the personnel in need of assistance, and ensuring that affected individuals get access to the right treatment at the right time.

[35] All-Party Parliamentary Group on Arts, Health and Wellbeing Inquiry, 2017 "Creative Health: The Arts for Health and Wellbeing" London. See also the AARRTS program described previously.

[36] Ramirez J, 2016 "A Review of Art Therapy Among Military Service Members and Veterans with Post-Traumatic Stress Disorder" Journal of Military and Veteran's Health, Volume 24 No.2.

Conclusion

Discussion at the Roundtable pointed to the need for first responder organisations to develop a comprehensive and sound mental health and wellbeing strategy. This needs to be married with other organisational strategies described in the previous chapters and with access to sound evidence-based treatment options. Roundtable participants with mental health expertise were keen that mental health strategies should not be pathology-based but rather promote wellbeing, and that they should enable the first responder to have agency in promoting their own wellbeing and seeking assistance if they feel they need it. Treatments offered should be evidence-based. However, there is concern that a large proportion of health professionals are not following evidence-based guidelines in diagnosing and treating people with PTSD. Organisations can contribute to remedying this situation by ensuring that their contracts with service providers require provision of evidence-based treatments. In addition, research into the needs of those who are refractory to treatment, while outside the direct responsibility of first responder organisations, is critical, and support to continue this research is extremely important to the welfare of many of their members.

THE SPECTRUM OF CARE IS BROADER THAN THE MEDICAL MODEL

Mental health is part of the holistic spectrum of understanding the person, and we need to think about mental health itself as a continuum. We are all on a continuum around mental health and we all fluctuate on it on a daily basis.

CHAPTER 8: THE VIEW FROM THE TOP

POLICE AND OTHER FIRST RESPONDER BUSINESS IS TOUGH. IT IS UNPREDICTABLE, STRESSFUL, VERY DEMANDING AND FREQUENTLY URGENT. EXPECTATIONS ARE HIGH FROM ALL QUARTERS. THE CHALLENGE FOR LEADERS IS TO ENSURE THEY UNDERSTAND THE RISKS AND, AS FAR AS HUMANLY POSSIBLE, DO NOT MEET PUBLIC DEMAND AT THE EXPENSE OF THE HEALTH AND WELLBEING OF THEIR OWN PEOPLE.

Former AFP Commissioner Mick Palmer

Introduction

It was evident at the Roundtable that the leadership-level participants who attended were fully engaged in the issue of post-traumatic stress, how to manage it and how to minimise its impact on their personnel. There may be an element of self-selection in this — as those most engaged in the issue were the most likely to attend — but we believe that first responder organisations as a group are well-informed about PTSD, concerned about it and looking for answers. Accordingly, we do not expect that anything in the material that follows will come as a startling revelation to the senior leaderships of first responder organisations.

Senior leadership in first responder organisations have a range of functions including taking responsibility for overall performance of the organisation, developing vision and policy direction, ensuring that resources match requirements, setting role models for people in the command chain, establishing and maintaining the organisational culture, balancing competing strategic priorities, and managing high-level external relations. Senior leadership also encompasses strategic managerial functions, such as ensuring that the organisation has the right people in the right jobs. This chapter will touch on some of these aspects, raised in discussion and subsequently.

Multifaceted (and sometimes competing) responsibilities of senior managers

The senior managers of first responders have 360-degree responsibilities. They are responsible to their political masters for raising, training and maintaining the capabilities of the organisations they lead: for having in place the standing capability to respond to the types of incidents that fall within the scope of the organisation's mission.

They are also responsible to the public for the overall performance of their organisation in carrying out their respective duties, and accountable to their governments and parliaments for that performance. Any significant failure, especially one that involves death or injury, will lead to an inquiry and close scrutiny of the actions of all concerned, from those charged with organisational preparedness to those in command of the operation, to those on the front line.
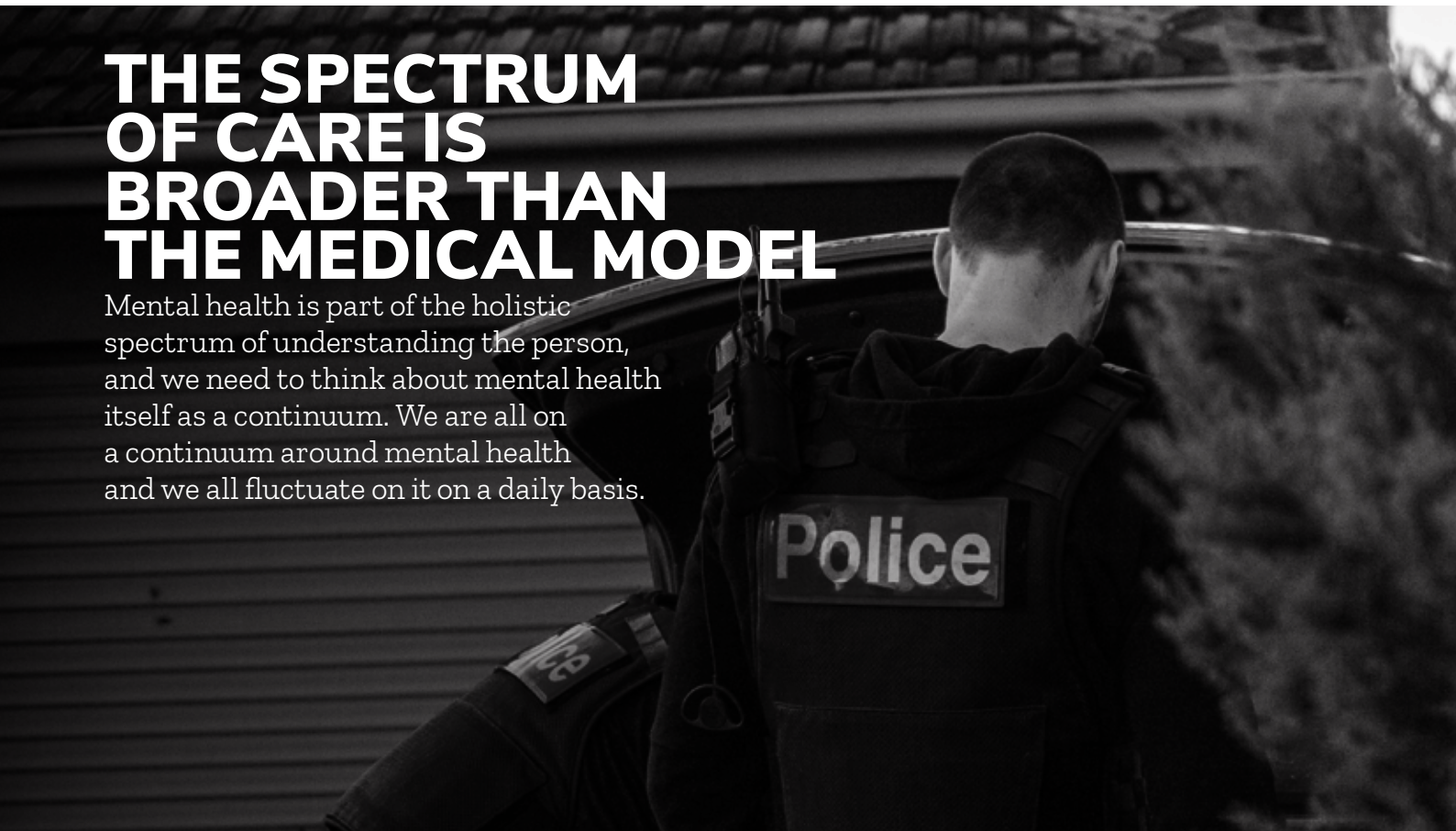
They have equally important responsibilities at the operational level to the public they serve. The most obvious of these is of course to deliver, as efficiently and effectively as possible, and in a timely manner, the services their organisation was created to provide. Perhaps less obviously they have a duty to ensure that none of the personnel they dispatch represent an avoidable risk to the public — for example, that the judgment and capability of armed responders, or those charged with driving emergency vehicles at speed, are not unduly compromised by mental health issues or sheer exhaustion.

The difficulty for senior managers is that in some circumstances the important duty of care they have for their own personnel has to be balanced against their responsibility to deliver their time-critical services to the community. The reality is that, in many of the most dangerous situations, doing nothing — or not responding (which would protect their personnel) — is not an acceptable option either politically, operationally or even, where lives are at risk, at a community level.

However there are organisational initiatives senior managers can put in place which mitigate the competing risks inherent in their working environments. The fact that first responders are among the few organisations that ask their staff to take risks to their own health and safety in the course of their work creates, in our view, a higher duty to ensure that all of their tools of trade are fit for purpose and in first class working order.

To the extent that it is possible, senior managers should ensure that:
- The screening of potential recruits is successful in identifying those who have the physical and psychological stamina to undertake the challenging roles they will undertake.
- The training regimes they institute prepare people physically, technically and psychologically for their roles, and enable them to maintain perishable skills (e.g. weapons skills, precision high speed driving, first aid skills).
- Their practices have regard to the applicable workplace health and safety laws. As noted previously, this is not easy in the challenging environments in which they operate.
- The support systems they have in place encourage wellbeing, normalise reactions to traumatic stress, and provide appropriate assistance without stigma to those who need it.

Efficiency and effectiveness in the first responder environment

It is also important to understand, in relation to the leaders' responsibilities, that 'efficiency' and 'effectiveness' are not synonyms. Efficiency has to do with performing a given operation at least cost, and about making resources go as far as they can (getting the most 'bang for the buck'). Effectiveness has to do with successful completion of missions. When it comes to a major incident in any first responder domain, the public will rightly prioritise effectiveness over efficiency. If a bushfire is brought under control rapidly, no one is going to complain that the task could have been accomplished by a smaller number of firefighters.

It is not always so straightforward, however. The first responder environment is complex, demanding and often unclear. Judgments and decisions frequently have to be made on the basis of incomplete information. This reality needs to be well understood in any examination of operational effectiveness. For example, if too few firefighters attend because a manager believes some are too exhausted to go back in the field, and community lives are consequently lost, the community is likely to be less than pleased and the manager is likely to be asked a number of difficult questions — operationally, politically and in the media.

So it needs to be understood that first responder tasks are face-to-face operations that require staffing determined by the nature and scale of the task. Contemporary political and central agency rhetoric about 'efficiency dividends' and 'learning to do more with less' makes little sense in these environments: it is a matter of matching personnel to tasks. Organisations which fail to do that, and governments that fail to provide for that, will put loyal and committed personnel under avoidable risk and strain, compromise organisational performance and compound the problems we are trying to deal with here.

The right people for the right jobs

There is more in this simple phrase at the senior management level than meets the eye at first glance. 'The right people' is not just a matter of staff selection: people need to be shaped for their jobs, not simply selected for them. As the graduating trainee enters the operational workforce, the organisation must ensure that at every level, before being promoted or reassigned, he/she is shaped by training, and the organisational culture and ethos, to be 'the right person' for the job. No one enters any organisation with all the attributes required to perform well in it — they acquire much of what they need along the way, by a process of maturation at each level.

'The right jobs' is not a matter of the suitability of the person to the job, it is about organisational design. The senior executive must ensure that the organisation chart is designed to enable the organisation to carry out its mission efficiently and effectively, that every position on it needs to be done and represents a reasonable workload for the individual assigned to it, and that there is no work that needs to be done which is not represented by an appropriate number of positions on the organisation chart.[37] Again, these tasks require judgments and decisions that in many cases will only prove their value and accuracy after the event. This said, the importance of training and awareness to good decision-making cannot be overstated and is at the heart of the challenge.

Establishing an appropriate resourcing model

Given the initial premise that keeping the workforce healthy is a capability issue, the level of resourcing should facilitate healthy workplaces and hence the prevention of PTSD, and prioritise the wellbeing of staff over treatment of problems that were not identified and responded to in good time. The rationale for resourcing should not imply the inevitability of PTSD. Since prevention is much cheaper than cure, resourcing needs to be provided for prevention as well as for treatment, with a view to recovery should PTSD occur. A leadership-level police participant suggested:

There are two ways you can frame the question about resources and stress. The first is resourcing sufficiently to prevent stress and having sufficient resources to allow downtime. That has more chance of success with government than saying if people are stressed you need more resources to get them well.

Typically in policing organisations, public expectations and politicians' conversations, police resources are all about servicing crime, but it isn't just about servicing crime; it is a more fundamental question about the resource level needed for the safety of the police station and making sure that the resource base is generous enough to ensure the people in the station are being looked after. You take that out of the equation and then you look at what you need to service demand — we still need the task force approach, we still need to tackle crime — but we are talking about understanding what it takes to run the infrastructure of a police station as separate from service demand.

This means that the size of teams will have to provide for rotation through periods of duty and periods of stand-down, probably in the form of light duties or back office work.

Relations with other organisations

It is also the responsibility of senior leadership to set the terms and tone of relations between their organisation and other relevant organisations both within their jurisdiction and in other jurisdictions. This goes to sharing information, doctrine and tactics and, at peak times, the sharing of personnel. Shared principles and practices in dealing with matters such as how to manage the mental health of seconded personnel, for example, would not only improve the experiences of personnel, but would also have capability implications across the nation.

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37 Conceptually each organisation has four organisation charts, only one of which is written down: (1) How the organisation is meant to work — that ideal 'org chart' floating in the ether somewhere that would render precisely the intent of those who brought about the organisation's establishment and of those who are now politically accountable for it; (2) the formal organisation chart which is how the leadership team has encoded its understanding of the intent on a sheet of paper; (3) how everyone in the organisation thinks it works; and (4) how it works in practice, as a result of the combination of formal and informal lines of command and communication. The effects of personalities, skills and resourcing can lead to these four versions diverging significantly from one another; a wise leadership is constantly seeking to make the four of them as similar to each other as can be achieved in the real world.

A national framework for mitigating traumatic stress and responding to PTSD

The Roundtable revealed considerable variability in management responses to post-traumatic stress and the quality of organisational services provided to first responders at risk or suffering from it. At the same time several examples of useful reviews and good organisational practice were provided which could be shared for the benefit of all.

This led to the suggestion that a more structured mechanism for sharing information across first responder jurisdictions would be productive. This sharing would be strengthened by undertaking a national audit to ascertain how well the systems currently in place actually help people, and where they fall short: 'At the moment we depend on the stories but we don't actually have data.' Finally, as a function of developing working relationships with other organisations, the leaderships of first responder organisations could consider the benefits of adopting a national framework for mitigating traumatic stress. The excellent work in developing guidelines already undertaken by organisations such as Phoenix, Black Dog and *beyondblue* could be used both to guide the audit and to develop the framework, and the inter-jurisdictional sharing mechanisms which have been put in place by police and other services could be built upon for the dissemination of information.

In this context it is worth looking at developments in Canada, which is currently considering a private member's bill to create a national PTSD framework to track the disorder, establish national guidelines for diagnosis, treatment and management, and create education materials to be used by public health providers. In Ontario, Canada's largest province with a population of 14 million, organisations that employ first responders are required to provide PTSD prevention plans to the Minister of Labour. These plans are posted on-line as a way to share good practice. As well, a strategy has been introduced which includes:

- A PTSD awareness campaign,
- An annual leadership summit to recognise leaders and to monitor progress in dealing with PTSD,
- A free on-line PTSD toolkit for employers,
- Research grants to support the prevention or mitigation of PTSD.[38]

Speaking out and educating the community

Senior leaders also can also be influential in helping the community understand what PTSD is, how it can occur, and the best ways to respond to it. Fear of community stigma in addition to that perceived to exist in the workplace was reported as another factor inhibiting first responders from speaking up about their stress. It also impacts on the families of those with PTSD. One person suggested that community education about PTSD should be undertaken in schools, but there are also many opportunities for senior leaders to champion the cause of people with PTSD in the public domain. Strong support from the community can be a powerful influence on political decision makers.

Gaining political support

It also falls to the leadership group to work directly to obtain the necessary political support for more effective approaches to post-traumatic stress in first responders. This support is vital: it will determine the outcome of resourcing decisions; it will facilitate any legislative or regulatory changes that may be necessary; and it will help to shape the national conversation about this widespread problem. One leadership figure with a police background said:

We've got to accept and embrace and promote at an organisational level that trauma is a work-related hazard, it's a normal part of the work we do, it's a risk that they expect us to take in the work they expect us to do. There is no better time to run that argument than now in 2017 Australia. There are lots of voices in the game and I think you could undersell the power of the combined voice of first responder agencies in this country. If you had a single voice without even going beyond our own boundaries, if there was a single primary responder voice going to government, you'd have a pretty strong argument.

Concerning both seeking political support and shaping the national conversation, a former police officer who now advises and assists on PTSD issues said:

There are 3,600 groups beating the drum about PTSD and suicide. I think that has created a negative conversation about how bad the situation is and we've lost focus on the fact that there are some organisations doing exceptionally good work to help people understand about PTSD and also to instigate measures to help them take responsibility for their own health and not have to rely on organisations to help them. If we can start to focus on the programs that are working and proving to be successful, I think people and politicians will support our organisations more than they have in the past.

A police association member said:

We don't have the necessary champions in politics among our elected officials. They are the ones that control the budget we get, the ones that require us to do the work that we do and they are the ones who often tell us we need to do more with less — and from our perspective those savings go from the wrong areas.

This should be something at the level of COAG where all the respective ministers actually talk about it — because we are all suffering the same things, for example needing more money. We need to have those folk know that what we do is dangerous and comes with consequences. The people we put into authority actually have to help us. To get that national dialogue going — that would be exceptionally useful. Hopefully, they would come to a resolution which provides a pathway with the resources and the support that we need to be able to make sure that our people stay healthy.

Uniform and appropriate Workers Compensation legislation

Of direct relevance to COAG is the question of uniform and appropriate standards of workers' compensation. The various States and Territories within Australia and each category of emergency service have different work cover legislation. As well, under the current legislative arrangements there is an understandable focus on minimising compensation costs, which means that opportunities for prevention are subordinated to the tendency not to identify those who are unwell as this may lead to compensation claims.[39]

There are many anecdotal accounts suggesting that dealing with workers' compensation authorities can exacerbate the mental stress of those who acquire an 'invisible' injury like PTSD and seek compensation. It is likely that this source of stress in those affected by PTSD in first responder organisations is widespread[40]. Insurers typically apply a rules-based protocol for determining liability that can expose the injured member to further trauma (by having to tell his/her story again through an independent medical process) and further anxiety through time delays and apparent needless hurdles. Insurance agencies have a large role to play in redefining the process for claim acceptance to protect the individual rather than cause harm, and senior management must lead the process of securing their cooperation in developing these redefined processes.

We are aware that presumptive legislation has been introduced in the Canadian provinces of Alberta, Ontario and Manitoba, which in general terms allows their workers' compensation board to presume that, if a worker is exposed to certain types of traumatic events and is diagnosed with PTSD, it is caused by the worker's employment, unless the contrary is proven. The intention of the presumption is to reduce stigma around mental illness and to make it simpler in some cases to establish a causal connection between PTSD and a worker's employment. Workers' compensation legislation is not nationally consistent across Canada, however, and this can cause additional problems for those affected by PTSD.

Such legislation in Australia would normalise PTSD in first responder organisations and in the community. It would lift the veil on this invisible injury and give first responders confidence to seek help. It would force cultural change in first responder organisations and endorse the efforts of their leaders to get their houses in order, to raise awareness, promote resilience and self-care, encourage peer support, provide evidence-based psychological assistance and adapt RTW policies. It also needs to be recognised that presumptive legislation is predicated on the application of sound diagnostic standards. It does not help people to get the particular help they need if every mental health issue that occurs in a workplace is deemed to be PTSD.

The authors regard the introduction of uniform presumptive legislation to be a potential game changer that ought to be examined for adaptation to Australian circumstances. An initial step would be a summit of key stakeholders from government, heads of first responder organisations, unions, professional health care associations and leading experts to examine options around this issue with a whole of system focus and in the context of developing a national framework for mitigating and managing PTSD in first responder organisations.

As noted above, we need to be alert to the risks of a too narrow focus on PTSD to the exclusion of other mental health conditions. We are not attempting in this report to deal with all the mental health issues faced by first responder organisations, but to avoid unintended consequences we need to see PTSD in its full context. Unless we reduce the stigma about all mental health conditions, those with Depression/Anxiety/other trauma presentations may be either misdiagnosed, or seek to skew their diagnosis in order to fall into the more 'legitimised' category of PTSD.

Conclusion

Senior managers have unique opportunities to shape the way PTSD is handled both in their own organisations and in society more broadly. Just as the system will fail first responders if operational managers are not doing their jobs effectively, if the organisational settings are not right, if the individual is not empowered to take responsibility as far as possible for their own mental health, and if the treating professionals fail to meet their expertise and skills obligations, so too the system will not deliver the outcomes needed if senior managers do not stand up and use their influence to improve the understanding of PTSD in their own organisations and in the broader community.

They have an important role to play in communicating to the community that we cannot continue to receive the quality of first response we have come to expect at the expense of the mental health of the first responders who provide it. Most importantly, those at the top are well-placed to get the priority of responding to PTSD onto the political agenda and if necessary stimulate the impetus for legislative change.

38 Taken from a statement by Ontario's Minister of Labour, Kevin Flynn, provided to Dean Yates in August 2017.

39 Alexander McFarlane, "Traumatic Stress: the uncounted cost"
40 Nick McKenzie, Richard Baker and Nick Toscano reported in "Dirty tactics by insurance companies make injured workers miserable" *The Age*, 11 September 2016, that 44.5% of police mental health claims were rejected, compared to 4.7% of those involving physical injury. While mental health is broader than PTSD, it is safe to assume that a significant number of these cases would have involved PTSD (article available at **https://www.theage.com.au/national/victoria/dirty-tactics-by-insurance-companies-make-injured-workers-miserable-20160909-grd648.html** accessed 16 March 2018).

DISCUSSION AND SYNTHESIS

MAINTAINING ALL PERSONNEL AT HIGH LEVELS OF PHYSICAL AND MENTAL HEALTH GOES TO THE HEART OF ORGANISATIONAL CAPABILITY

CHAPTER 9:
MANAGING PTSD RISKS IN THE FIRST RESPONDER WORKFORCE

Introduction

This chapter synthesises what was said at the Roundtable by participants with lived experience, participants responsible for their physical and mental health and wellbeing, and participants who lead first responder organisations.

It is clear from our inquiries, and discussions with first responders and those who lead them and manage their wellbeing, that PTSD and related conditions are a major issue for first responder organisations of all types.

The case for the leaders of first responder organisations to give the issue high priority rests on moral, legal and public policy grounds:

- The moral case is that everything reasonably possible should be done to protect the health and wellbeing of those who put themselves at risk on behalf of the community, and the health and wellbeing of their families.

- The law of the land in every jurisdiction in Australia establishes obligations for all employers in relation to the workplace health and safety of their staff.

- In a public policy sense, organisations have a responsibility to take all reasonable steps to ensure that employees with first responder duties enjoy and maintain high levels of physical and mental health, both as a workplace health and safety obligation and to ensure organisational effectiveness and capability. Maintaining all first responder personnel at high levels of physical and mental health goes to the heart of organisational capability.

- The social and economic costs of not responding are very high via social disruption and suffering — not only of the person affected but also of their family, the high costs of treatment compared to prevention and early intervention, and overall lost productivity.

The first responder leaders and senior managers we spoke to are well aware of the seriousness of the problem and are putting measures in place to deal with it. We had a receptive audience — at no stage did we feel we had to convince anyone that this is a high priority problem that needs to be dealt with.

First responders accept that exposure to confronting situations is inherent in their jobs, that there will be times when they are personally at risk, and that there is a significant probability that over the course of a career they will face situations at the extreme end of the spectrum. In some callings — including street level community policing, the investigation of violent crime and fatal and serious traffic accidents and, as para-medics or emergency ward doctors and nurses, attending to injured, distressed and frequently highly stressed citizens — this exposure is regular. The fact that these people voluntarily put their health and at times life and limb at risk does not in any way reduce the responsibility employers have for their health and safety. On the contrary, it increases that responsibility — this fact must be recognised as a fundamental part of the social contract between those who put themselves at risk on the community's behalf, and those who employ them.

There is a tension between the requirements for a formal diagnosis of PTSD and the managerial responsibility for the health, safety and wellbeing of staff. As noted in Chapter 2, full diagnostic criteria are not met until at least six months after the trauma(s), although onset of symptoms may occur immediately. While it is sound management practice to provide information on the impact of trauma-related stress and ways of mitigating it as a preventative measure, the requirement for direct intervention cuts in as soon as symptoms appear; the managerial imperative is to intervene early and ensure that the affected individual receives prompt treatment with a view to complete recovery. For this reason, in the discussion that follows we prefer terms like trauma-related stress rather than PTSD.

Strategically there are essentially three ways to control the incidence and impact of trauma-related stress:

- Control exposure to potentially traumatic events
- Mitigate the impact of sub-clinical exposure
- Ensure that impacted personnel are identified and referred promptly for assessment and treatment by the best available specialists.

At the same time, it must be recognised that on current indicators, once PTSD develops, about one third of cases will prove refractory to current treatments.

It will be clear that from both a financial and a human cost point of view, intervention and management become more expensive as one goes down the above list.

Controlling exposure to potentially traumatic events

It is generally accepted that repeated exposure to traumatic events elevates the risk of PTSD. Given that exposure to potentially traumatic events is inherent in the duties of first responders, the question is how often, and at what intervals, people can be exposed to them without undue harm. The evidence is that this varies greatly from individual to individual, and there is, as yet, no definitive research on the best way to manage exposure to the events that are routine in first responder organisations. In the absence of this knowledge, managers are required to make informed decisions about what is 'reasonable' and, within that framework, to remain alert for signs that individual officers are struggling. This managerial responsibility, however, needs to be balanced against the reality, including the unpredictability and extremely urgent nature, of many first responder Queensland floods, the recent wild fires in the USA, the Christchurch earthquakes, and the Bourke Street rampage in early 2017, the question of 'reasonable hours of duty and/or exposure' have to be ignored, or are overtaken by, the urgent nature of the demand and the overwhelming imperative to save lives.

These extreme but, sadly, far too frequent situations cannot, however, allow the over-riding responsibility for the welfare and safety of employees to be ignored. Indeed, the increasing frequency of violent and extreme events increases the importance of effectively managing employee welfare both to protect employees and to ensure the maintenance of organisational capability and preparedness.

The risk is undoubtedly increased for all personnel by too high an operational tempo, with the stresses inherent in the duties being compounded not only by insufficient time between operations to unwind, but by insufficient and poor quality sleep, so that coping mechanisms are compromised and the impact is compounded. These factors need to be understood and particularly well-managed in quieter times, if organisations and their personnel are to respond effectively and with expected resilience in times of disaster or extreme emergency.

The risks can arise not only from the rate of actual operations, but from spending too much time on call. The lack of 'down-time', whether due to being on call or engaged in operations, compromises not only the capacity to recover before the next call-out, but relationships within the family and with friends. This can be cumulative, even over many years, and can occur at all levels of seniority. In on-going resilience terms this can be a 'silent killer'. Managers and organisations have a long practised tendency to 'flog willing horses' and, in the absence of complaint, may not recognise the warning signs until too late.

Given the importance of this issue we are attracted to a suggestion made at the Roundtable that a credible system to track cumulative exposure to trauma be developed and introduced to enable those officers with a high degree of exposure to be identified as a matter of routine. This would not only facilitate timely treatment, it could contribute to the management of those personnel so that the need for treatment is reduced.

In the absence of definitive knowledge about what constitutes reasonable exposure and how to predict individual reactions, a pragmatic approach might be, along the lines of the approach taken to airline pilots, to limit the number of hours a person is permitted on certain front-line duties in any given week or month. This would reduce the potential for a surfeit of exposures, and would enhance the opportunities for first responder personnel to have adequate sleep and adequate opportunity to look after their own fitness, health and wellbeing.

An alternative would be to introduce regular stand-down periods for first responders — say one week every three months. This would be regarded as time on duty and would not be part of their sick leave or recreation leave. In order to maintain operational effectiveness it would be necessary to backfill the positions but, in many cases, a rotational system could be implemented which would both reduce the staffing demands and remove the stigma that may otherwise attach to the stand-down process.

In larger metropolitan stations an alternative to a complete stand down, involving a period performing back office or support functions away from the front line, is likely to be practical and achievable. Small posts in remote areas would require special consideration as limiting hours on duty would be impracticable; when an incident occurs the one or two people at the small post are likely to be the only people within effective reach and they will need to be called out. Periodically standing them down with a replacement taking over their duties is likely to be a more practicable approach.

One calling for which devising a way to control exposure to potentially traumatic events would be difficult is undercover police work. The nature of undercover work frequently requires living a double life to mix closely with organised criminals, including violent criminals. The work also requires a commitment of time sufficient to establish credibility within the criminal group. Whilst these factors make it imperative that people are selected with great care and even then only if they volunteer, the risks of undercover operations are unavoidably high. The control of operatives is fraught and needs to be managed with full appreciation of the risks of trauma-related stress. While it may be difficult to control exposure in these circumstances, preserving mental health and wellbeing should be given particular attention in preparing and supporting personnel undertaking undercover assignments and in the debriefing phase.

Across the spectrum of trauma/stress management, whatever approach is taken, the resource implications need to be understood and recognised. Almost certainly more resources will prove necessary, to avoid having people constantly on call and being over-exposed, with insufficient recovery time, to traumatic incidents. Now that so much is known about PTSD, its precursors and its consequences, it would arguably be negligent if the resource implications were ignored. This is discussed below in relation to issues for senior managers.

Over-exposure not only affects front-line personnel. It can also affect office personnel engaged in processes such as victim identification. This can perhaps be best handled by establishing safe operating procedures and ensuring via supervision that they are adhered to.

Mitigating the impact of potentially traumatic events

Strategically, the approach to mitigating the impact of potentially traumatic events may be summarised as:

- Selecting people with the required physical and psychological stamina
- Giving them the right training
- Managing their wellbeing, and giving them the skills to do so.

Within that framework there is a spectrum of measures that can help to mitigate the overall impact of potentially traumatic events and the incidence of PTSD. The consistent message from the Roundtable was that a whole of system approach is needed if we are to prevent PTSD, and should that fail to provide the best recovery options. Components of that system include:

- Staff selection and training
- In service refresher training
- Training and supporting those who manage operational personnel
- Adopting a 'wellbeing' rather than a 'pathologising' approach
- Encouraging people to come forward early and removing the perceived impediments to them doing so
- Ensuring timely access to state of the art treatment
- Maximising available support mechanisms.

Staff selection and training

We have no reason to believe that the nation's first responders are not recruiting people with the requisite physical and psychological stamina. We certainly believe that those who successfully complete their training will have demonstrated they have those prerequisites. The question then is whether there are aspects of their training that can make them less likely to succumb to the stresses of their work, more likely to recognise that they need help, more likely to come forward, and more likely to recognise danger signs in their workmates and encourage them to come forward.

The solution to this lies in the direction of:

- Acquiring a better understanding of the psychological makeup of recruits at the pre-recruitment screening stage, in order, in the words of a senior police participant, to be 'alert to what people bring with them and make sure we are in the business of being able to manage it'.

- Briefing potential recruits, and perhaps a family member or trusted confidant(e), at the point of recruitment, on situations that are likely to arise in the course of a career in the relevant first responder service.

- Making it an integral part of a recruit's training — one on which they are examined — to teach them about
  > physiological and psychological responses to trauma, and that they are a normal reaction for a healthy well-adjusted person,
  > coping mechanisms,
  > the symptoms to look out for, what they are expected to do if they become aware of those symptoms, and what they are expected to do if they see signs of post-traumatic stress in others.

- These should be presented as an occupational hazard, on a par with and no more shameful than physical injury. People would present for treatment if they sustained a gunshot or knife wound, a blow to the head or a significant burn; they must be encouraged to see psychological injury in the same light.

- Training recruits on the management of their own wellbeing via appropriate nutrition, exercise and adequate sleep.

In-service refresher training

Understanding of PTSD has increased greatly in recent years but much remains to be discovered about manifestations and treatment, and many cases remain recalcitrant to current treatments. We can expect current research will fill many of the gaps in the foreseeable future.

In parallel with this, well-run first responder organisations will evolve their practices and their expectations of staff and their managers.

Accordingly, we cannot expect that the understanding acquired during initial training will last the individual a lifetime. Given that sound psychological health is seen as a strategic part of organisational capability, periodic updates and, at a lower frequency, refresher courses on post-traumatic stress and its management must be seen as an integral part of in-service training.

Training and supporting the managers

There were comments at the Roundtable that people are promoted on the basis of their technical skills without regard to their people skills. One middle manager commented that he would not have known what to do if someone had come to him with symptoms of post-traumatic stress, and there was some unambiguous commentary by several impacted personnel to the effect that their managers did not know how to deal with them. To the extent that this reflects current practice, it must change.

Promotion on technical skills is to be expected, but as soon as someone is promoted to a level at which they become responsible for the direction and oversight of others they should receive leadership training, specifically:

- Training in relation to their workplace health and safety responsibilities in general,

- (Re)training on post-traumatic stress, its causes, symptoms and treatment,

- Briefing on the precise steps they are required to take when one of the people they are responsible for discloses or begins to manifest symptoms of post-traumatic stress,

- Information about the assistance available and how to encourage those who need it to access professional expertise — whether provided in-house or externally.

To a large extent the focus on technical skills as the basis for promotion is as it should be — people need to be good at their job, especially when it can mean the difference between life and death for either the officer or someone they are trying to assist. Nevertheless the ability to lead and manage people becomes important as soon as an individual is promoted or appointed to a role that involves responsibility for the activities, deployment, management and welfare of others. Even if this does not come naturally, most people can acquire the requisite leadership and management skills via appropriate training.

An important point for first responder organisations, and one they should emphasise to all personnel in supervisory roles, is that professionals with expertise in providing assistance to people impacted by exposure to traumatic stress should be seen as a resource not only to support the front-line personnel who face potentially traumatic situations, but as a resource and source of advice for the people who manage them.

Building a healthy first responder workplace

Roundtable participants with mental health expertise were keen to see that mental health strategies should not be pathology-based, they should rather promote wellbeing, and they should enable the first responder to have agency in promoting their own wellbeing and seeking assistance should they need it.

There was a lot of discussion about the perception that there is stigma attached to succumbing to PTSD or, short of that, displaying 'weakness' in the workplace in response to potentially traumatic events. Some advocated dealing with this via awareness campaigns, and we see a role for these, but we would also agree with those who firmly put the view that there is a limit to what awareness campaigns can achieve. Some people are not going to change their minds in response to awareness campaigns and there comes a point at which diminishing returns set in. Beyond that point any funds spent on additional awareness endeavours would be better spent in other ways, e.g., better treatment standards for impacted personnel.

As noted in Chapter 4,[41] one senior psychologist commented that stigma is just one of many negative attitudes and beliefs it is difficult to control, and rather than try to control it we should put our effort into the behaviours we want to see, the outcomes we want, and what we are wanting people to do differently.

This leads directly to the importance of building a healthy first responder workplace. We have already noted the mental health review conducted for Victoria Police[42], which found that protective factors in the workplace include work team level leadership support, well-defined work priorities, having a say in implementing those priorities, a collegial learning-oriented environment which encourages debate and feedback about how the work is done, and a climate that validates wellbeing and early help-seeking behaviour as part of the way business is conducted. We endorse these findings.

An essential foundation for early help-seeking behaviour, as well as the establishment of an open, healthy atmosphere in the workplace, would be embedding in organisational culture, policy and practice the principles that:

- it is normal for the things first responders see and do to affect them,

- it is normal when they are so affected to seek support or backup, and

- it is normal with that support and backup to get better.

Of vital importance is the shift of emphasis from regarding PTSD as an illness to the emerging focus on wellbeing. Under the traditional approach, everyone is assumed to be 'OK' until they are not — whether physically or mentally — after which they are referred for treatment of an injury or illness. The 'wellbeing' approach is a more proactive one of saying that first responders do difficult, dangerous and potentially traumatic things as a matter of routine, and if we want them to be 'OK' we have to take positive steps to ensure they are, and we need to monitor how they are going so we know the state of play with each person's wellbeing and fitness for duty. This means that the focus of education and information is not pathology-based, and that seeing a counsellor becomes a routine matter of individuals looking after themselves rather than seeking treatment after they have reached breaking point.

Highly relevant here is the notion of a 'continuum of mental health', rather than a binary notion that people are mentally either well or unwell. This involves recognition that everyone has ups and downs in their lives, all have periods of depression and periods of joy, and we move backwards and forwards along a line rather than being either on or off it.[43]

Intrinsic to the building and maintenance of a healthy workplace will be recognition of the importance of post-traumatic growth, to which reference has been made earlier in this report,[44] and using it in the framing of an organisational approach to mental health. The point was made that while some individuals may be psychologically injured given the nature of first responder work, many more, given the right environment, information and interventions, are likely to remain well and even, potentially, to derive psychological and spiritual growth from their experiences.

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41 Chapter 4, page 27.

42 Chapter 5, pp 30ff.
43 Chapter 4, p. 28.
44 See Chapter 4, pp 28ff.

The maintenance of wellbeing must be established as a co-responsibility between the organisation and the individual. Staff have both a right and a responsibility to ensure their own wellbeing. The organisation can assist its staff by increasing literacy and openness about mental health, mainstreaming understanding of the neuroscience of traumatic stress, and reinforcing the notion of joint responsibility. It must also do all in its power to ensure that the operational tempo permits personnel the down time to take care of their own fitness, nutrition, sleep and spiritual wellbeing, all of which contribute to the individual's resilience.

Encouraging people to come forward early

Progress is being made in establishing an understanding that there is nothing shameful about reporting symptoms of trauma-related stress, but there is a long way to go. Operational personnel will be understandably reluctant to seek help while they see any risk that their trust in their organisations bona fides might be misplaced — that if they put their hand up and receive an unsympathetic reaction there is no road back. Accordingly, the stories of people who self-report receiving appropriate support and treatment and returning to normal duties will play a vital role in establishing the appropriate culture and requisite levels of trust.

Beyond that, there is a need for clear and declared processes regarding what will happen if people 'put their hand up'. Any uncertainty about the process, or about the fairness and integrity of the process, will lead to people attempting to conceal a condition that might be dealt with relatively easily in its early stages.

While concern about the impact on career seems to be the principal consideration affecting the willingness of first responder personnel to seek help, as noted in Chapter 4 and in the preceding section, another factor that made personnel reluctant to speak up is the feeling that stigma is attached to being diagnosed with a mental health condition. There was a consensus that the impact of operational situations on mental health needs to be accepted as part of the job and discussion of it normalised.

A third factor is the self-image of first responders. These are strong, resilient people and, perfectly reasonably, this is the image they have of themselves. It is entirely understandable that some of them react with a form of denial — 'this can't be happening to me, I'm just a bit tired, I've been working too hard, nothing a good night's sleep won't fix'. Overcoming this barrier is likely to be assisted by normalising the idea that trauma-related stress can happen to anyone. As one participant said, reacting to traumatic stress is a sign that a person is psychologically normal, capable of empathy, and not a psychopath.

Timely access to best practice treatment

There is a great deal now known about PTSD, and understanding is evolving. Knowledge about the treatment of PTSD is strongly evidence-based and well delineated. Unfortunately, however, not everyone gets access to the best treatment, a situation compounded by the fact that PTSD is difficult to diagnose and there is no 'one size fits all' PTSD treatment.

There are a variety of reasons for difficulty of access. One is significant variability in how the diagnosis is made. As noted already, the first contact is often with GPs, who frequently lack the skills or expertise to diagnose PTSD appropriately or may not be across best practice in the area. This can flow on to referrals for treatment, and lead to a gap in getting the right treatment for the right illness.[45] We heard some strong adverse commentary about the performance of external providers — doctors, psychiatrists and psychologists.[46]

Another problem is over-diagnosis of PTSD by medical professionals who are poor at differentiating industrial issues (e.g. under-performance or poor behaviour in the workplace) from clinical issues. This can lead, paradoxically, to under-diagnosis of those who actually have PTSD.[47]

There was considerable disquiet expressed about the state of employee assistance programs (EAP), some of which are staffed by in-house counsellors, some by external providers, some with counsellors highly trained in PTSD, some staffed by generalist counsellors with no specific skills in PTSD. Some provide face-to-face counselling, others provide phone-in services without continuity of contact.[48]

We agree with the recommendation in guidelines published by Phoenix Australia:[49]

Practitioners who provide mental health care to emergency workers with PTSD, regardless of professional background, must be appropriately trained to ensure adequate knowledge and competencies to deliver the recommended treatments. This requires specialist training, over and above basic mental health or counselling qualifications.

According to expert and experienced voices at the Roundtable, these guidelines are not universally applied. As stated in Chapter 7, this is a serious breakdown in the system of care with severe consequences for PTSD-affected first responders.

In saying this we are conscious that mental health services of any kind are much easier to access in metropolitan centres than in regional centres, let alone the remote locations in which many first responders work. Nevertheless, in looking to the wellbeing of staff, each first responder organisation needs to consider how it will deliver timely and accurate access to all staff wherever located. The organisation has a duty to ensure their people are getting the best treatment available in that window of opportunity within which that treatment is most likely to be efficacious.

Where reliance is placed upon external providers, care and skill are required in drawing up and managing service provider contracts and in a willingness at all levels of management to insist that the organisation is delivered the level of quality service it is paying for.

No matter how high the quality of service provided, it needs to be recognised that the provision of effective treatment for PTSD is a complex matter: different individuals will respond differently to different treatments, some will be highly resistant to particular types of treatment, some resistant to any form of treatment. The treatment regime must be well-timed and designed to meet the needs of the individual in question, and it will require development of trust and confidence between the patient and the person designing and delivering the treatment.

In developing these treatment regimes, recognition must be given to adjunct therapies such as mindfulness training and creative arts programs in fields like writing, music, visual arts and drama.

Finally, policy and practice must acknowledge that even if a person has access to the right treatment at the right time, research shows that 30–40% of people presenting with PTSD symptoms do not respond to the treatments offered.

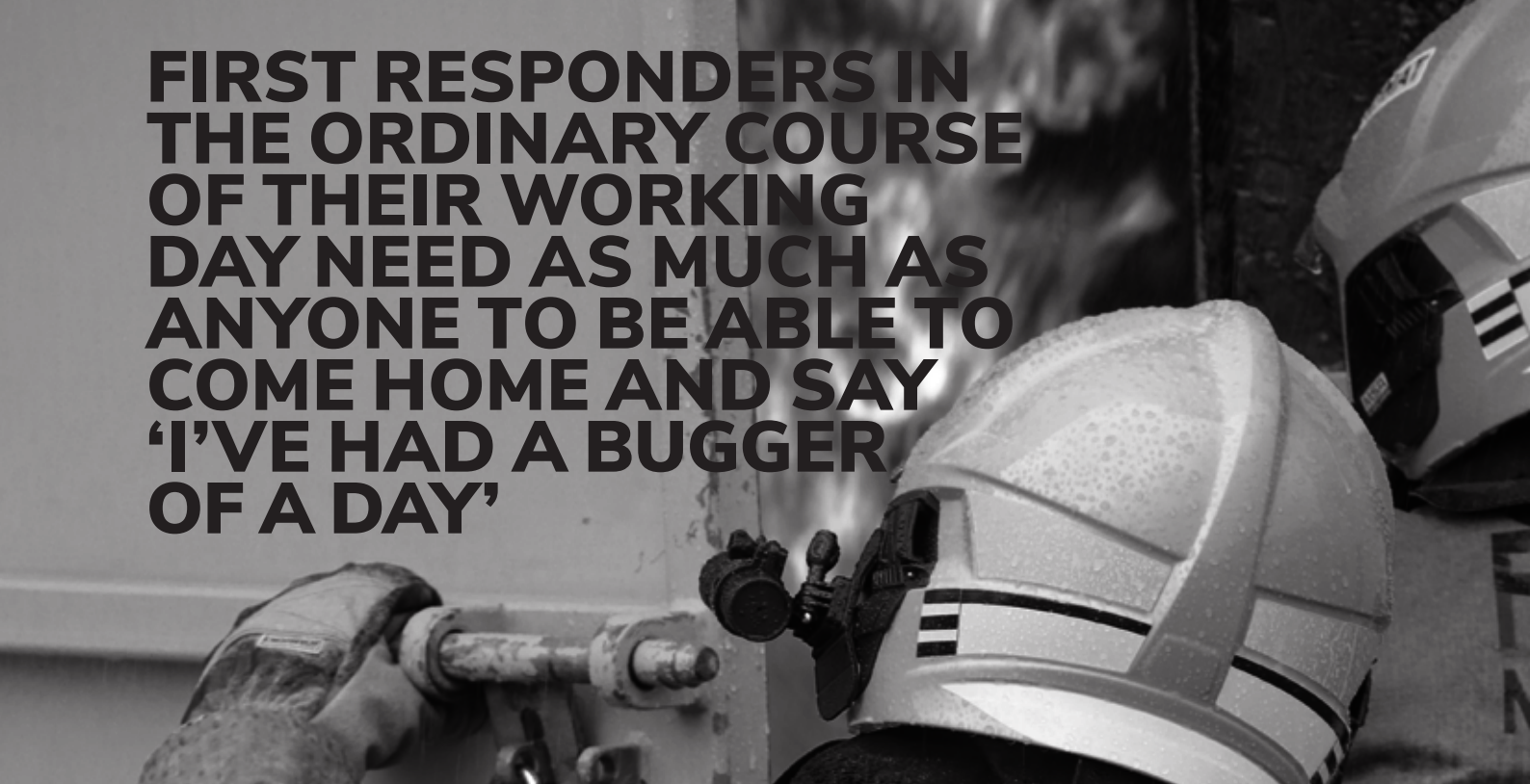## Maximising access to available support mechanisms

There are many support mechanisms that can strengthen the resilience of first responders including, importantly, the opportunity for regular, relaxed interaction with family and friends and to pursue interests outside work. While not directly 'PTSD support' these are fundamental to the development and maintenance of the necessary feeling of wellbeing.

Other mechanisms include:
- The support of family and friends
- Peer support
- Support of line management
- Mentors
- Knowing that the work is valued.

The support of family and friends is relevant both in everyday life and when the going gets rough. For this support to be available and effective, these people need to understand the nature of the duties and the stresses imposed on first responders. This is best communicated by the individuals themselves, but organisations can facilitate the process by having available prepared talking points in non-technical language about both the duties and the impacts.

Beyond that, first responders in the ordinary course of their working day need as much as anyone to be able to come home and say 'I've had a bugger of a day' and talk about it to an appropriate extent, rather than attempting to maintain a stiff upper lip and pretend all is well. When people come under more severe stress, the need to be able to talk about it to sympathetic members of their immediate circle is all the greater.

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45 Chapter 7, p. 45.
46 *Ibid.*
47 *Ibid.*
48 *Ibid.*
49 Chapter 7, p.46

FIRST RESPONDERS IN THE ORDINARY COURSE OF THEIR WORKING DAY NEED AS MUCH AS ANYONE TO BE ABLE TO COME HOME AND SAY 'I'VE HAD A BUGGER OF A DAY'

Peer support within the workplace is analogous to that of family and friends — it is important all the time, and important in a different way when an individual is starting to struggle. It is particularly important because work colleagues are best placed to understand the nature of the duties, what the person is going through, and the circumstances (including the managerial and leadership context) in which the problem has arisen. This peer support can only be fully effective in a healthy workplace in which people can talk openly about what is affecting them without detriment to their social standing or their career.

When first responders are impacted to the point that they are at home on sick leave, the requirement for support becomes more demanding and more specific to the affected individual. Their families need guidance as to the best ways they can help the person to recover, and they themselves need support. Contact from the workplace needs to be carefully calibrated to the individual's needs. A few individuals will not want to hear from anyone unless it is completely necessary; they will not want to be reminded of the workplace and the circumstances which have given rise to their current situation. Most, we believe, would like to be contacted from time to time, but they will probably be highly selective about the people from whom they would welcome a call, and there may be individuals they feel they never want to hear from again. The suggestion was made, and it makes sense to us, that each individual should nominate with their employer the names of two or three people as authorised points of contact between them and the organisation should they need to take stress-related leave.

Line managers can support their officers in many ways. If they are good leaders, they will be among the individual's most important mentors. The best support they can give is to perform their own duties with full effectiveness: to give clear guidance and direction, both about specific tasks and regarding overall conduct; to make clear to their staff what is expected of them; for those expectations to be reasonable when measured against the resources provided; to allocate tasks and resources fairly; to be a key source of on-the-job training, sharing the benefits and insights of their experience; to counsel and coach when performance falls short of expectations; and to communicate appreciation of a good job well done, or done as well as could have been expected in the circumstances. Supervisors with highly developed leadership and managerial skills can bring their people on and give them the confidence to face their duties with the necessary equilibrium. Supervisors who lack these attributes will be an additional source of stress.

This brings us to formal mentoring. This can play an important role. The mentor needs to be someone whom the individual respects and trusts. It is not the mentor's role to be a friend to the individual; rather, the mentor can assist with the provision of dispassionate advice informed by an understanding of the duties to be performed and the constraints within which the organisation operates.

Finally, there is the question of recognition of the services that are rendered by first responders. In a related context, a police participant called for retired police to be given something like the recognition that military veterans are given. We suggest that more public recognition and celebration of the contributions first responders make would help to dispel the doubts many must feel from time to time about whether all the pain and suffering is worth it. Additionally, retired police and other career first responders can be an extremely valuable mentoring or support source.

SERVICE NEEDS TO BE RECOGNISED

More public recognition and celebration of the contributions first responders make would help to dispel the doubts many must feel from time to time about whether all the pain and suffering is worth it.

CHAPTER 10: DEALING FAIRLY WITH IMPACTED PERSONNEL

Introduction

Unfortunately, the best efforts of first responder organisations notwithstanding, some personnel will develop symptoms of post-traumatic stress as a result of their experiences in the line of duty, and will need to take time off work. Some will recover to the point where they are ready to return to the workplace, either in their previous operational role, or perhaps temporarily or permanently in a non-operational role.

Whether or not they return to the workplace, some will have their lives complicated by the fact that an incident in which they were involved is the subject of an inquiry and/or litigation. There is also the likelihood that they will face a difficult time with insurance companies establishing that the damage they have suffered is a direct consequence of workplace incidents.

Return to work

RTW is a tricky issue that needs to be handled sensitively and for which the solution needs to be tailor-made to the individual. The key issues are:

- The assessment of an individual's fitness to RTW should not be made in a binary way, deeming as unfit anyone who is not in a state to be fully effective in their previous role.
- Consideration should be given to whether there is scope for officers returning to work to be given lighter duties or supporting roles for a time, as part of a planned and phased pathway to a full return to their normal role. For many, being back in the workplace rather than languishing at home will be beneficial — some of our participants said so. The appropriate level of remuneration will be a consideration here — should they be remunerated in a line with their lesser responsibilities, or should they, as injured personnel, be paid in accordance with the role that gave rise to their injury? We would incline to the latter.

- Allowance should be made for the individuals who will not be ready to return to the workplace at all until they are approaching full recovery, because the workplace itself is likely to trigger painful memories and set back the recovery process.
- As noted above,[50] for many impacted personnel RTW needs to be seen as part of the recovery process, not something that happens subsequent to it. From the point of view of aiding recovery, it is important to find the best job for the returnee rather than just fitting them into an available slot. If this means a degree of tailoring of a position to suit the individual, we suggest this would be a step worth considering.
- People returning to work in a different role should not be placed in the humiliating (and probably debilitating) situation of being foist upon someone who doesn't want them, doesn't know how to handle them, and doesn't know what to do with them. The best remedy is for senior management to have an appropriate conversation with potential line managers to inform them of the situation and to identify someone who is willing to accept the individual and play a role in their recovery. In-service managerial level training should aim amongst other things to develop an understanding of and commitment to the importance of supporting people in this situation.
- Similarly, when a person returning to work is being introduced into a workplace in which he/she is not known, the people who are about to become their colleagues need to be briefed in a sensitive manner that is not counterproductive to the person's chances of being accepted as a member of the team.

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[50] Chapter 6, p. 39.

Post-incident issues

As noted in Chapter 2, it is difficult to predict why some people develop PTSD and others do not, but some of the factors include repeated exposure without recovery time, exposure to consequent stressors (e.g. legal proceedings, occupational problems, financial concerns, media scrutiny) and availability of support. This means, inter alia, that first responder organisations should do what they can reasonably do to minimise the impacts of inquiries or legal proceedings consequent upon an incident in which an individual has been involved, and of media intrusions. This is not in any way to suggest that any such incident is not a legitimate object of media scrutiny, nor to suggest that individuals should not be held accountable for their actions once the facts have been ascertained. Rather, we are saying that while the appropriate processes are on foot, the individual(s) concerned should be shielded by their organisations from avoidable pressures.

Participants also suggested that the frustrations of dealing with workers' compensation authorities can exacerbate the mental stress of those who seek compensation for an 'invisible' injury like PTSD. While it is understandable that organisations would seek to minimise the cost of compensation, this should be achieved through greater investment in prevention and early intervention, not through an adversarial system which hounds first responders suffering from trauma-related stress, who may already be vulnerable to feelings of shame and worthlessness, to 'prove' that the injury has arisen from the workplace. First responders diagnosed with PTSD should be spared the agony of insurance companies following them around to gather evidence that things aren't as bad as they claim, and employers should play a role in this.

Legislative relief could also make a difference. As mentioned, presumptive legislation has been introduced in the Canadian provinces of Alberta, Ontario and Manitoba. This provides a legal framework for the presumption that, if a worker is exposed to certain types of traumatic events and is diagnosed with PTSD, it is caused by the worker's employment, unless the contrary is proven. The intention of the presumption is to make it simpler in appropriate cases to establish a causal connection between PTSD and a worker's employment.

While it would be difficult to achieve, the introduction of uniform presumptive legislation in Australia would have the potential to normalise PTSD in first responder organisations and in the community, noting the important caveat that presumptive legislation must be predicated on the application of sound diagnostic standards, an area that still needs attention in Australia. It does not help people to get the particular help they need if any mental health issue that occurs in a workplace is deemed to be PTSD.

LEGISLATIVE RELIEF COULD MAKE A DIFFERENCE —
...by establishing a legal framework for the presumption that, if a worker is exposed to certain types of traumatic events and is diagnosed with PTSD, it is caused by the worker's employment, unless the contrary is proven.

CHAPTER 11: POLICY ISSUES

Introduction

The preceding discussion raises a series of higher level policy issues that require consideration by senior managers, by policy makers, and by those who make the decisions about the resources first responder organisations will have available to them.

Issues for senior managers

In Chapter 8 we discussed the complex series of responsibilities and accountabilities of top management — their responsibilities to Parliaments, Ministers and the public to deliver their organisation's services safely, effectively, and cost-effectively, and their important responsibilities to the personnel they lead to:

- Recruit people with the requisite physical and psychological stamina
- Institute training regimes that prepare them physically, technically and psychologically, and that maintain perishable skills
- All within the framework of the applicable workplace health and safety laws.

We also discussed the important distinction between efficiency and effectiveness — that 'efficiency' and 'effectiveness' are not synonyms. Efficiency has to do with performing a given operation at least cost, and about making resources go as far as they can (getting the most 'bang for the buck'). Effectiveness has to do with the successful completion of missions. Too much emphasis on efficiency (e.g. not having highly trained personnel perform back office functions) can compromise the capacity of the organisation to rotate front line personnel through lighter duties.

Senior managers need also to recognise, and to persuade their political masters, that first responder tasks are face-to-face operations that require staffing levels determined by the nature, scale and duration of the task.

Ultimately this comes down to a matter of resources. The public can have as much in the way of first responder services as they are prepared to pay for, but these difficult and dangerous services cannot be conjured up out of thin air and attempts to do so (essentially by flogging wiling horses) will result in destruction of the lives of highly trained, committed and valuable people and their families. Leaders of first responder organisations must be prepared to defend the social contract ('if you do this for me I will look after you') to the world at large, including to political leaders who don't want to face up to this inconvenient truth.

One of the difficulties in organising effective interventions is that responsibilities for those at risk are spread between government departments such as Defence, police, family and community services, health and the criminal justice system. There is also a concern by employers at the need to minimise compensation costs. Prevention and treatment services are often poorly coordinated across organisations within a state, let alone nationally. There is not — and needs to be — a national strategy for developing consistent high-quality evidence-based systems of prevention and treatment for at-risk populations. Senior managers have an important role to play in advocating strongly for a more coordinated and comprehensive approach to this national issue.

The Roundtable revealed both considerable variability in management responses to post-traumatic stress and several examples of useful reviews and good organisational practice that could be shared for the benefit of all. A more structured mechanism for sharing information across first responder jurisdictions would be productive. There may also be benefits in adopting a national framework, as is currently being considered by the Canadian parliament, for mitigating traumatic stress in first responder workplaces. The excellent guidelines already undertaken by organisations such as Phoenix, Black Dog and *beyondblue* could underpin the development of the framework.

Issues for resource allocators

In this category we include both the government ministers and the central agencies (Treasury, Finance etc.) that assist them to draw up and administer the annual budget for the jurisdiction they govern. We understand the nature of the problem. All functions of government have their importance, and there is never enough to go around. At its heart, economic management is about how the body politic deals with scarcity, and the resource allocation decisions that are made will necessarily reflect a blend of social and political priorities.

We would simply ask of both the governments and the central agencies that advise them to ensure that their expectations of the first responder organisations in their jurisdictions are commensurate with the resources they are prepared to allocate. By our reckoning, managing the health of people exposed to potentially traumatising events is going to require a stark choice between more resources and less service. The community owes the men and women of the first responder services a huge debt: we expect them to be there and ready when we need them at all times of the day and night, in all weathers and in all circumstances. The least we can do is enable them to meet our expectations without compromising their health and wellbeing, through ensuring they are sufficiently resourced.

FINDINGS AND RECOMMENDATIONS

PREVENTION AND TREATMENT SERVICES ACROSS EMERGENCY SERVICES

are seldom coordinated across organisations within a state, let alone nationally, so there is no national strategy for developing consistent high quality evidence-based systems of prevention and treatment.

Professor Alexander Fleming

CHAPTER 12: FINDINGS & RECOMMENDATIONS

Introduction

The quotation which introduces this chapter has been chosen because it draws attention to a major deficiency in Australia's approach to PTSD in first responder organisations — the lack of a coordinated and consistently evidence-based approach to dealing with this issue.

What we heard at the Roundtable and in subsequent commentary leads us to believe that better management of trauma-related stress in the first responder workforce requires sustained attention in these four main areas:

1. Managing the health risks of trauma-related stress in the first responder workforce.

2. Achieving the best treatment and care for impacted personnel.

3. Facilitating the sharing of knowledge and encouraging more research to generate better understanding of PTSD and its management.

4. Developing a national approach for sharing information and improving understanding of the issue among politicians, within central agencies, and with the general public.

These are matters that need to be pursued at the level of individual organisations, at the sector level (police, fire, ambulance etc.) and at a national first responder community level.

A national strategy to mitigate and manage trauma-related stress in first responders could provide many benefits, but it should not be seen as the first and only step. While a coordinated national strategy might be the gold standard, in the real world a national strategy does not necessarily bring about change on the ground. Attempts to develop national strategies in Australia may be fraught with Commonwealth/State and Territory politics, with consequent long delays — particularly if the necessary foundations have not been laid in advance.

Nevertheless, this approach should not be abandoned.

In the meantime, much useful groundwork can begin in individual organisations right now, to make ongoing improvements in the lives of first responders and their families affected by trauma-related stress. Drawing on emerging brain research, the excellent work already undertaken in developing clinical and management guidelines for PTSD, and on the many pockets of good practice that exist in first responder organisations across Australia and overseas, there is plenty that individual organisations can do now to mitigate risk of trauma-related stress and to improve treatment options for affected staff, without waiting for others to move.

This can provide a solid base for a well-thought and effective national strategy at the right time. Even without a formal strategy, there is advantage in a coordinated and coherent approach. This will require senior leaders to look across to their colleagues in other first responder organisations as well as up to their political masters and down through their lines of command. If it is agreed to pursue the recommendations of this report, it may be necessary to set up a cross jurisdiction taskforce/working party or some other process for coordination and review.

Some of the findings and recommendations in this chapter are major initiatives requiring additional resources, others relate to day-to-day dealings that could make a difference without affecting operations or needing significant additional resources. They are mutually reinforcing rather than exclusive, but for ease of reading they are presented under the four headings identified earlier.

The high rates of mental health conditions experienced by first responders, emergency service workers and volunteers
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PTSD IN FIRST RESPONDERS report

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1. Managing the health risks of trauma-related stress in the first responder workplace

Findings

- There is value in providing evidence-based information on trauma-related stress, its effects on the brain and how to mitigate it, to first responders at recruitment and throughout their careers.

- This benefit is increased when families and loved ones are briefed — with first responder consent — on the risks of the first responder workplace, the symptoms of trauma-related stress and how best to respond if the first responder becomes affected.

- Managers and supervisors also need training and support to deal effectively with trauma-related stress in the first responder organisation.

- Personnel health and wellbeing are an organisational capability issue and should be managed as such.

- There are known circumstances and clear warning signs when trauma-related stress may be affecting first responders and managers need to know what these are and how best to respond.

- First responders themselves have a responsibility to manage their own health and wellbeing and the organisation has an obligation to facilitate access to assistance when it is needed.

- To manage capability, emphasis should be placed on 'people-focused leadership' with associated accountabilities at all levels in the first responder organisation.

- A base level of operational tempo should be established which is departed from only under exceptional circumstances.

- Participants at the Roundtable agreed there would be benefits in giving people management, self-management and peer support much greater attention.

Recommendations

1. Review recruit screening and selection processes to ensure intending recruits are briefed on the mental health risks inherent in their calling.

First responder organisations should develop high-quality materials on the stressful nature of the organisation's mission, and the nature of the spectrum of stress responses, to inform briefings to intending recruits to ensure they understand and accept what they are getting themselves into. This should be supported by a short written statement, which the recruit would be asked to sign to indicate they have had the briefing and have read and understood the material.

We suggest that:

- The aim of the briefing is not to deter suitable applicants, it is to ensure informed decision-making and also to prepare people for the more confronting aspects of their future role. It is also an opportunity for the organisation to develop an understanding of the attitudes that recruits bring with them.

- The aim of signing-off is not to dilute organisational liability for the workplace health and safety of their staff, it is to encourage intending recruits to approach the matter with the seriousness it deserves.

- Intending recruits should be permitted to bring a family member or trusted confidant(e) to the briefing so that in coming to their decision they have opportunity to discuss the matter afterwards with someone who has heard the briefing.

2. Ensure training on trauma-related stress — including how to recognise it in self and others, how to mitigate its symptoms and how to access assistance if they need it — is made an integral part of the first responder training curriculum; this information should be embedded at recruitment and reinforced throughout the first responder's career.

It is clear that early identification, and treatment where necessary, of symptoms of post-traumatic stress greatly enhance the impacted person's chances of the recovery. While people have a responsibility to monitor their own health, supervisors have a particular place in noticing when a staff member is starting to struggle. They may be in the best position to initiate a low-key conversation about how the individual is travelling and whether they need a reduced tempo or time off, but the supervisor needs to know what to look for. The training could include:

- Information on the causes and nature of PTSD and related stress responses, the symptoms to look out for, and techniques for self-management of stress responses.
  > There is now a great deal of information from neuroscience on the effects of trauma on the brain and the benefits of adopting calming techniques to bring brain function back to equilibrium following exposure to trauma. Several at the Roundtable talked from personal experience about the benefits of this, and it would be useful to make this part of the first responder toolkit — to be introduced at recruitment and regularly refurbished throughout the first responder career.

- The contribution of nutrition, exercise, adequate sleep and overall fitness and wellbeing to the management of stress.

- The impacts of cumulative exposure to trauma and the importance of wellness checks and trauma tracking.

- What they should do on becoming aware of particular symptoms or levels of symptoms.
  > Organisations might consider whether there are symptoms or levels of symptoms at which it becomes mandatory for personnel to seek professional assistance.

- The impact of peer support.
  > Organisational sanctioning of peer support is important. Peers can be crucially important in helping to create a workplace atmosphere where speaking up is accepted, in recognising when a colleague may be showing symptoms of traumatic stress that they themselves may not yet be aware of, and in providing support at all stages of treatment and recovery.

- How best to manage and support someone returning to work after sick leave for trauma-related stress.

- It must be made clear that suffering arising from such exposures is predictable and not shameful, and accordingly that seeking help is not a career limiting move; on the contrary, presenting in a timely manner for advice and treatment is to be applauded.

3. Seek permission from first responders to brief their families on the risks and the symptoms of trauma-related stress.

It was recognised at the Roundtable that individual first responders are the gatekeepers regarding access to their families, and that it would be inappropriate to seek to contact the family without the individual's permission. Nevertheless, the first responder's immediate family shares the risks associated with first responder work, and is probably in the best position to identify when things start to go wrong.

The benefits of involving families were strongly reinforced by support organisation participants. The strain on families is increased when they do not understand what is happening and feel powerless to help their affected family member. Information can help to relieve this stress and give options for supportive action. Accordingly, front-line personnel should be strongly encouraged to permit their families to be briefed.

4. Mandate people-management training for all supervisors and managers in first responder organisations — this should include identification of early symptoms of post-traumatic stress, and management of impacted personnel returning to work.

People management in the first responder environment has competing demands, particularly in times of emergency when the community may expect that the immediate priority of the task should come first, with the longer-term wellbeing of the first responder being dealt with later.

Acknowledging this, Roundtable participants clearly felt that people-management could be improved and that a culture and practice of compassionate people-management in first responder organisations would have a flow-on benefit to those affected by PTSD and thus to capability. While technical skills should play an important role in the selection of first responders for promotion, their leadership potential should be assessed and all those moving into supervisory roles for the first time should be given leadership and people-management training. That training should explicitly include training on management of the mental health and wellbeing of first responders, and (re)-training on the management of post-traumatic stress, and the procedures to be followed in relation to affected personnel under their supervision.

Return to work is a critical time in the recovery process for impacted personnel. Handled well, it can make an important contribution to the individual's prospects for recovering full effectiveness and their sense of wellbeing. Mishandled, it can adversely affect the individual's prospects, perhaps leaving them in a limbo in which they are not ill enough to be invalided out and not well enough to become fully operational and lead a normal life. Accordingly, personnel returning to work should never be exposed to a supervisor who is not both ready and willing to take them, and to contribute positively to their recovery.

Several organisations are already mandating people-management training and providing dedicated support to managers in their complex people-management role. This should be a feature of good practice in first responder organisations.

5. Acknowledge personnel health and wellbeing as an organisational capability issue that should underpin operational policy and procedure.

First responder organisations spend a lot of time on operational training and this is to be commended, but it is not enough. While machinery and technology are tools of the trade, performance and capability are still determined by the human factor. The point was made emphatically at the Roundtable that maintaining the health and wellbeing of staff is not just a matter of compassion, it is critical to organisational capability. Most recommendations in this section reflect this principle.

6. Embed into organisational culture the mantra that 'it is normal for the things we see and do to impact us; it is normal when we are so impacted to seek support or backup; and it is normal with that support and backup to get better'.

There was important discussion at the Roundtable about people's fear of being stigmatised if they seek help. We were persuaded there are limits to what can be achieved in this regard by education campaigns, and share the view that emphasis needs to be placed on setting out and encouraging the behaviours we would like to see. The intention here is to normalise the perception of post-traumatic stress as an occupational hazard, rather than a sign of weakness, failure or illness. The stress reaction is a normal response to abnormal events.

7. Establish a base level of operational tempo, to be departed from only under exceptional circumstances.

There was discussion about the cumulative effects of too high an operational tempo so that front-line personnel are constantly sleep deprived, a problem compounded by the fact that the shocking situations they deal with mean they get poor quality sleep.

We suspect that too high an operational tempo also makes it difficult to meet nutritional requirements — that personnel will become habituated to grabbing something at the nearest fast food outlet.

We believe that the stresses of first responder work, together with the requirement for first responders to be healthy and alert, impose an obligation to limit exposure to high-stress situations. This is not to ignore the reality that there are times when it is 'all hands to the pump' until the crisis has passed. On the contrary, it recognises that such occasions will occur, and that in order to sustain the necessary effort during these peak times, front-line personnel must be in reasonable shape before they start.

Accordingly, during 'normal' times, first responders should be operating at a tempo they can sustain week after week. We suggest that, somewhat akin to the practices of passenger airlines, first responder organisations consider establishing a maximum number of front-line hours that a first responder can generally be called upon to perform in a month, recognising that from time to time there will be situations that require an emergency footing when all personnel, or certain designated specialists, are required to be available until the situation is under control.

The Australian public can have as much by way of emergency services as it is prepared to pay for. We are failing the people who put themselves in harm's way on our behalf if we expect them to work excessively because we, the public, are not prepared to provide them with resources matched to the tasks we expect them to undertake.

8. Implement specific operational arrangements for front-line personnel to have regular scheduled 'down time'.

Several participants referred to the toll of being 'on call' virtually all the time, manifest in some cases as a stress reaction every time their mobile phone rang. No one is suggesting that first responders should not be on call, but there must be regular and predictable times they can call their own, so they can invite friends around for a barbecue, or take their children to the beach or the football, and know they will not be disturbed.

9. Ensure managers and supervisors are made aware that the psychological support services of the organisation are there to support them as well as front-line staff.

Several impacted personnel said that when they returned to work their supervisor did not know what to do with them, or how to relate to them, and we heard operational managers say that if someone had come to them seeking help in relation to post-traumatic stress they wouldn't have known what to do.

All first responder organisations have units that can provide or organise psychological support for front line personnel. It needs to be made clear that these units are also able to provide advice and support for the managers, and that the managers are encouraged to use them.

10. Emphasise 'people-focused leadership' with associated accountabilities at all levels.

While we are all ultimately responsible for our own wellbeing, managers can have a huge impact on the wellbeing of staff and have a responsibility for ensuring the workplace is conducive to staff wellbeing.

This requirement can be fulfilled in part by the people-management training referred to in Recommendation 4. It would also be assisted by an organisational culture that promotes and rewards managers' dual responsibility not only to complete the mission but also to look after their people. The culture needs to give them confidence that the decisions they make in balancing these responsibilities will be respected, and that if they put their hand up and say there is a problem, they too will be respected.

11. Ensure clear and transparent written protocols about how to get assistance, and what support is available from their organisation, are in place to guide first responders seeking help for trauma-related stress.

We have noted that early intervention holds out the best prospects of recovery. A corollary of the proposition that the stress reaction is a normal reaction to abnormal events and there is nothing shameful or career-limiting about it, is the obligation to be able to arrange any necessary interventions in a timely way. Each organisation should establish clear written guidelines setting out the circumstances under which first responders are required to present themselves for examination and any necessary assistance or treatment.

It was very clear at the Roundtable that concern for their future career made many first responders reluctant to admit to any post-traumatic stress problems or to seek help. Some said they had hidden their problems for years. Some said they had wanted to come forward but didn't know what would happen if they did.

It essential that first responder organisations dispel any doubts on that score. We recommend that each organisation establish clear and transparent written protocols so that all personnel know how they will be treated, what the procedure is, that they will be treated exactly the same as all other personnel in like circumstances, and that they will be treated fairly. We believe this step will contribute to the normalisation of the perception of post-traumatic stress in the workplace.

12. Consider assigning mentors to all first responder personnel, including supervisors and managers.

In the complex and demanding first responder environment, which of necessity requires hierarchy, formal mentoring is an important support mechanism which enables front-line personnel to have a confidential discussion with a more senior and experienced person they trust, while retaining control of their situation. Accordingly, it would support the objectives of Recommendation 11 by addressing people's concern people that if they put up their hand for help their situation could spiral out of their control.

13. Develop and implement a PTSD prevention and management plan.

This suggestion, drawn from the mandated practice in Ontario already mentioned, could be based on many of the recommendations in this report. While a prevention and management plan does not ensure results, it would be an important driver for change. Ultimately we would like to see such plans shared on-line, as occurs in Ontario. This national sharing and recognition could be undertaken via an established clearing house (see Recommendation 28 below).

2. Achieving best treatment and care for impacted personnel

Findings

- While a range of evidence-based treatments is available, providing the appropriate treatment response to individuals is complex. Not all health professionals are appropriately skilled and experienced.
- It may still be difficult for individuals to find information about PTSD and available help.
- Organisations need to monitor the treatment provided by their Employee Assistance Programs to ensure it is evidence-based, appropriate and up to date.
- Impacted personnel often experience a lack of agency in the treatment process and need to be given access to the information that allows them to make informed decisions.
- Contact with the workplace while a member is on sick leave is generally valued, but this needs to be negotiated to suit the individual.
- There is growing anecdotal and other evidence that adjunct therapies such as those provided through the arts can be helpful for some people.
- Involving the family in the provision of treatment and support is beneficial.
- Dealing with the legalities of workers' compensation arrangements can worsen trauma-related stress — this has both procedural and policy aspects.
- Incident inquiries and intrusive media interest can add to trauma-related stress.
- Return to work is a critical point in recovery and needs to be sensitively managed. It can be challenging for the organisation to find appropriate duties, and salary anomalies can also be an issue.
- The first responder organisation is a special community. When personnel are no longer able to serve, support and recognition of their service may be both therapeutic and highly valued.

Recommendations

14. Ensure arrangements are in place in every locale to refer impacted personnel promptly to appropriately qualified medical and mental health practitioners.

There is significant variability in how diagnoses are made for those suffering symptoms of post-traumatic stress, and there are many reported deficiencies in ensuring that impacted personnel obtain the right treatment for the right illness.

This must change. Each first responder organisation, and preferably the first responder community as a whole in each jurisdiction, should maintain a registry of the GPs and specialists who have appropriate qualifications, training and experience, and issue directions for their personnel on where to seek assessment and any necessary treatment.

15. Support the establishment of a one-stop online shop for information about PTSD and available services.

Roundtable participants commented on the large number of organisations providing different information about various aspects of dealing with issues associated with PTSD. This can be very confusing for people who are affected by PTSD and searching for pathways to help. In a dynamic sector it is not always possible to maintain a current one-stop shop, but the benefits in terms of public perceptions and user convenience are clearly evident.

FearLess Outreach has indicated that providing a one-stop shop is one of its longer term aims. If achieved, this would provide a valued benefit to those looking for help.

16. Improve standards of PTSD diagnosis and treatment provided by internal and external service providers.

Managers, users of services and health care professionals at the Roundtable said poor standards of service from health care professionals are a major concern. Professional health care performance around diagnosing and treating PTSD is patchy at best and often poor.

A first step could be to engage with professional health care associations such as the Australian Medical Association and the Australian Psychological Society to improve performance in the diagnosis and treatment of PTSD. Instituting more auditing in this area would be beneficial. Mandating that diagnosis be undertaken by an accredited professional as part of the workers' compensation process may also ensure positive change.

Organisations could also review their Employee Assistance Program contract to ensure that service providers, whether internal or external, are appropriately trained to provide PTSD interventions, and that the services specified in the contract are fit for purpose.

Finally, there is a need to increase user participation in the design, delivery and evaluation of PTSD services. This is standard good practice in the mental health sector and is likely to assist in improving standards of care available to first responders. User participation processes could form part of the organisation's PTSD plan.

17. Maintain individually agreed channels of communication for contact with personnel on sick leave.

Peer support is important, especially when impacted personnel are enduring their symptoms and treatment away from the workplace. The question of which peers are in contact can be a sensitive one, however. We suggest each individual be asked to nominate two or three people as their preferred channel of communication, and that no one else should contact them except under exceptional circumstances. Nominations could be a matter of routine and updated annually (which would help normalise the idea that post-traumatic stress can happen to anyone), or done when the person concerned goes off on sick leave.

18. As appropriate, involve the family in the provision of support.

The family of the impacted person can play an important role in supporting and assisting recovery, but individuals' wishes regarding contact with the family must be respected. Impacted personnel should, however, be strongly encouraged to permit their family to be brought into the picture.

19. Recognise the value of adjunct therapies.

While in most cases adjunct therapies such as art therapy are not a substitute for medical and psychological treatment, there is emerging evidence and practice experience which indicates that they can make a valuable contribution as part of the health care continuum. First responder organisations should make arrangements to integrate access to these into their therapeutic toolkits.

20. Establish arrangements under which operational staff can return to work in a non-operational role, and without loss of operational pay.

Attitudes will vary, but many impacted personnel will want to return to the workplace as soon as they are able to, rather than sit alone at home. Even if they are not yet able to return to operational duties, return to work will facilitate access to the beneficial support of colleagues.

This raises the question of whether operational personnel should receive operational pay when on non-operational duties. To us, the situation is clear-cut. If these personnel remained on sick leave, they would receive their normal remuneration. They should receive no less if they opt to return to work ahead of being cleared for return to normal duty. This should be seen as a transitional period in the recovery process until they are cleared to resume their operational role. If and when it became clear they will never be fit to return to an operational role, this would become a compensation rather than a remuneration issue. They could presumably continue in their non-operational role, remunerated at the standard rate for the role, and compensated for both the damage they have suffered and the economic loss.

21. Assign a mentor to all personnel returning to work.

The process of returning to work is a critical part of the recovery process, and it is essential that returning personnel be posted into an informed and welcoming environment and given duties appropriate to their skills and stage of recovery, which may change as recovery progresses. This means each individual's return to work needs to be case-managed, and one effective way to do this is to appoint a mentor — a more senior trusted confidant(e) who is not in the individual's command chain — who would be accountable for ensuring that all goes according to plan or that remedial action is taken if something starts to go wrong.

22. Implement arrangements to minimise as far as possible the impacts of inquiries, legal proceedings or media intrusion consequent upon any critical incident in which an individual has been involved.

There will be times when incidents that give rise to post-traumatic stress are the subject of police investigation or judicial or parliamentary inquiry. While the personnel affected must give witness statements and/or appear before these inquiries as required, it is essential to ensure they are treated fairly, that no presumptions about their contribution to the incident are made prior to the outcome of the inquiry, and that impacted personnel are as far as possible shielded from the inevitable media interest.

23. Provide all appropriate support to impacted personnel in dealing with workers' compensation insurance companies.

Claims for compensation can result in protracted and highly adversarial processes, with insurance assessors doing their best to challenge the connection between the injury and the individual's employment, or to delay an assessment until the extent of recovery is established. This can be highly intrusive, with the individual being followed and photographed undertaking activities which the insurance companies allege are at odds with the nature, impact and extent of the damage claimed by individual.

In our view this engages two responsibilities on the part of first responder organisations. First and foremost, they have a duty to support their staff at a time when they have been injured in the course of their duties and when the stress of close-quarters combat with a well-resourced major corporation is bound to exacerbate their feelings of abandonment and despair.

Second, having regard to the fact that first responder organisations use taxpayers' money to insure their personnel, they have a duty to the general public to ensure they are getting what they are paying for.

Having regard to both of the above, we suggest the organisation should play a direct role in resolving each employee's compensation claim, supporting the claim with organisation-funded legal action where necessary.

24. Ensure that personnel who are no longer able to serve are given appropriate recognition at the time of their separation.

For PTSD victims who cannot continue with their chosen career, the pain and suffering of the injury and its treatment are made worse by the loss of identity that comes with separation from a close-knit community with a deep sense of purpose and strong bonds. Lack of recognition after separation was contrasted with the ongoing recognition accorded to military veterans.

It is important that the contributions of departing personnel be celebrated at the time of separation, and it would be desirable to develop mechanisms by which they can be made to continue to feel 'part of the family'.

3. Facilitating the sharing of knowledge and encouraging more research to generate better understanding of PTSD and its management

Findings

- There are gaps in knowledge about options for managing treatment-resistant PTSD and more research is needed.
- The first responder sector does not have access to reliable data about the extent of the trauma-related stress problem.
- While standards have been developed for managing mental health issues in first responder organisations, few appear to be using them in a systematic way.
- While examples of good practice were shared at the Roundtable, facilities for sharing best practice across the nation appear limited.

Recommendations

25. Establish a national PTSD epidemiological database.

There is no overall system for collecting even basic epidemiological data such as how many people are affected by PTSD, who they are, where they are, and how they are affected. Such data are fundamental to scoping the true extent of the problem, for developing policy responses, and for monitoring progress. Data definition associated with this work would also establish the shared lexicon needed to facilitate comparisons across different parts of the sector. Data analysis would provide a base for deeper research.

The pilot epidemiological study currently being undertaken by FearLess Outreach in the Illawarra/Shoalhaven area in partnership with the University of Wollongong and the University of Canberra is an important first step in this area. We hope it can be expanded to become a national project.

26. Establish relationships with universities to share research requirements and if possible commission relevant research.

The question of new forms of treatment for the 30–40% of people with PTSD who do not respond to current methods was identified as needing more investigation at the Roundtable.

Two-way links between universities and first responder organisations can help ensure that research outcomes are communicated to those who can make best use of them. There may also be an opportunity to influence the research agenda, even if first responder organisations are not yet in a position to fund research. This would seem to be an area where industry-academe partnerships could yield practical and beneficial results.

The high rates of mental health conditions experienced by first responders, emergency service workers and volunteers
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27. Conduct an audit of PTSD management against one of the established sets of guidelines.

An audit of organisational management of PTSD was suggested as a way of identifying what is working, what is not and what the gaps are. It would be sensible to conduct this against established guidelines such as *beyondblue*'s 'Heads up — Good practice framework for mental health and wellbeing in first responder organisations'. This could be done as a pilot project to test a process of organisational self-assessment and provide practical information that could be shared across the sector.

28. Establish a clearing house for research and good practice.

There was strong interest at the Roundtable in learning from organisations that are furthest down the path to good practice, including from related areas such as the military. As resources are precious, there is benefit in not reinventing the wheel. There are no mechanisms currently available to easily facilitate this. As well, Australian first responders need to be able to access national and international research and good practice if their approach is to be informed by the evidence.

FearLess Outreach has indicated informally that it is within their mandate to host a one-stop online clearing house via their website.

As these connections are strengthened, an annual award for good practice could be considered.

4. Developing a national approach for sharing information and improving understanding of the issue among politicians, within central agencies, and with the public

Findings

- There are a several policy opportunities that could improve outcomes for affected personnel, e.g. in relation to workers' compensation presumption, or through developing new resourcing models that take account of the particular circumstances of first responder organisations, such as the need for relief from high operational tempo.

- Roundtable participants felt that a united voice would have more impact in policy negotiations, at State and Federal level.

- Roundtable participants thought that community understanding of PTSD could be improved.

Recommendations

29. Build connections across the sector so that first responder organisations speak with one voice to government.

Several participants talked about the power of speaking with one voice to policy makers. This may require considerable dialogue beforehand, but it appears these conversations are taking place at senior levels and this is an important step in the right direction.

Others spoke about getting the language right when communicating internally and to the community. This is also important but can be difficult to impose. However, it will emerge more organically if common processes are introduced e.g. via data definitions in data collection, if common trauma-tracking systems are adopted, and if good practice is shared.

30. Work together to build the case for policy change in areas of mutual interest.

The implementation of big picture policy change may seem daunting, particularly as jurisdictions may differ in their approach. Nevertheless there is benefit for all in building the case for policy change, bearing in mind that a breakthrough in one jurisdiction can stimulate changes in others. Some of the policy issues identified at the Roundtable included:

- Introduction of presumption in workers' compensation legislation;

- The need for post-retirement support of injured workers, as for other veterans;

- Developing new resourcing models for first responder organisations to allow for occupational stress and the need to maintain capability, including flexible options for return to work;

- New resourcing models which take account of the need for additional staffing in workplaces regularly exposed to traumatic stress;

- The right to operational pay to be extended to injured first responders returning to work in non-operational duties;

- The extent to which a first responder's family can and should be involved with the organisation and how this can best be achieved.

While these are not easy policy issues, it would be useful to develop united advocacy positions to present to State or Territory governments or to COAG. A first step could be to bring together the key players to discuss the issues. Representation could be at a national or state level depending on the jurisdiction of the issue, and could include unions or other first responder associations, insurers, professional associations for medicos, psychologists and rehabilitation specialists, heads of first responder groups and government policy makers.

31. Identify PTSD champions and use them to raise awareness both in their organisations and in the community and to share good news stories.

Stories of people who have experienced PTSD, sought help and achieved improved mental health as a result are very powerful both in encouraging people who are experiencing traumatic stress to seek help and in explaining the condition to the wider community. Although the high levels of physical and mental distress associated with PTSD should be acknowledged and used to promote empathy and support, stories of recovery and growth are also very important to encouraging the momentum for change.

Final remarks

This is a long list of recommendations. While all are important, implementation will take time, and they will need to be prioritised.

In our view the key priorities are:

1. Within the broader context of growing community understanding that mental illness is not in any sense, a marker of a genetically inferior being but a response to life challenges that we all face, normalising attitudes to post-traumatic stress in first responder organisations and clarifying what happens when people seek help.

2. Normalising attitudes to post-traumatic stress in first responder organisations and clarifying what happens when people seek help.

3. Developing WH&S guidelines which outline the preferred or expected limits of exposure during normal operations.

4. Ensuring, as far as is reasonably possible, that impacted personnel receive, in a timely way, the right treatment for the right illness.

5. Implementing a case-managed return to work process for affected personnel, without financial penalty.

6. Supporting impacted personnel in dealing with compensation claims.

7. Introduction of the major policy changes outlined in Recommendation 30, including the introduction of a Canadian-style presumption in workers' compensation legislation.

8. Introduction of people management and mental wellbeing training for first responder managers.

9. Establishment of collaborative arrangements to build on work already done, including in Defence, to share good practice across jurisdictions and to advocate for improved treatment and policy options in the interests of all first responders.

THERE IS A NEED TO INCREASE USER PARTICIPATION IN THE DESIGN, DELIVERY AND EVALUATION OF PTSD SERVICES —

this is standard good practice in the mental health sector and is likely to assist in improving standards of care available to first responders.

WHEN HELPING HURTS: PTSD IN FIRST RESPONDERS

Report following a high-level roundtable

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RESTORING CONTROL TO VICTIMS OF TRAUMATIC STRESS

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