The Royal Australian & New Zealand College of Psychiatrists

Senate Standing Committees on Education and Employment

The role of Commonwealth, State and Territory Governments in addressing the high rates of mental health conditions experienced by first responders, emergency service workers and volunteers

June 2018

advocating for equitable access to services

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Royal Australian and New Zealand College of Psychiatrists submission

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About the Royal Australian and New Zealand College of Psychiatrists

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) is a membership organisation that prepares doctors to be medical specialists in the field of psychiatry, supports and enhances clinical practice, advocates for people affected by mental illness and advises government on mental health care. The RANZCP is the peak body representing psychiatrists in Australia and New Zealand and as a bi-national college has strong ties with associations in the Asia-Pacific region.

The RANZCP has almost 6000 members including more than 4000 fully qualified psychiatrists and around 1400 members who are training to qualify as psychiatrists. Psychiatrists are clinical leaders in the provision of mental health care and use a range of evidence-based treatments to support a person in their journey to recovery. In developing this submission, the RANZCP consulted with a variety of members, to ensure that priority areas identified reflect clinical experience, community input and mental health expertise. Interest from RANZCP members in this topic was substantial, which indicates the value of this topic to psychiatrists in Australia.

Summary

The RANZCP is pleased to provide this submission to the Senate Inquiry into the role of the Commonwealth, State and Territory Governments in addressing the high rates of mental health conditions experienced by first responders, emergency service workers and volunteers (the Inquiry). The RANZCP recognises the unique occupational risks associated with these groups and the poorer mental health outcomes associated with roles that expose workers to stressors and trauma.

In Australia, there are over 80,000 fulltime emergency workers who perform a vital role in protecting and providing emergency assistance to other citizens. As a result of their work, these Australians operate under very difficult working conditions and are regularly exposed to potentially traumatic experiences. There is increasing awareness and concern for the possible consequences of prolonged and repeated exposure to trauma. Evidence shows that large numbers of emergency workers experience symptoms of post-traumatic stress disorder (PTSD) and will be at risk for other mental health conditions.

This submission provides an overview of some of the issues relating to occupational risks for certain groups and the important role psychiatrists have in providing treatment, care and support. Content for this submission has been shaped around the areas identified in the Inquiry's Terms of Reference.

Recommendations

The RANZCP has identified areas in where the management of mental health in first responders and emergency service workers could be improved, with recommendations listed below.

1. Increase awareness and mental health literacy to encourage early help-seeking behaviour

- Implement mental health literacy initiatives to target staff in key leadership, managerial and occupational areas.
- Provide mental health training to prioritise mental fitness and build skills to self-appraise mental fitness and capacity. This should focus on early symptoms of distress (such as sleep disturbance and intrusive memories) and reduce punitive measures that are associated with raising mental health concerns (e.g. immediate removal of normal responsibilities).

- Expand and support awareness programs that focus not just on PTSD, but also other conditions that may be associated with emergency services work (e.g. depression, anxiety and substance use disorders).

2. Implement ongoing support, reviews and wellbeing checks

- Track incident exposure, with a certain number of incidents or specific incidents triggering wellbeing checks with managers or peer support officers.
- Provide annual health screening, with consideration for a cyclical approach to operational positions.
- Increase the roles and responsibilities for psychiatrists and clinical experts within emergency services organisations, the Department of Veterans' Affairs and the Australian Defence Force.

3. Ensure programs and services are evidence-based

- The RANZCP notes that psychiatrists are well placed to provide leadership around the development of evidence-based programs and services. Organisations should consult with specialists to ensure programs and services are appropriately designed and targeted.
- Implement systematic evaluation arrangements to assess the effectiveness of mental health support services, and to evaluate whether the organisation has in place the optimal services to target areas of highest risk. This was highlighted by the Australian National Audit Office in a recent audit of the Australian Federal Police (ANAO, 2018).
- Funding should be directed towards psychiatric research that establishes the causes, prevalence and best management strategies for mental health issues in first responders, emergency service workers and volunteers. A central repository of data from clinicians, researchers and emergency service organisations should be developed to inform policy and research.

4. Provide support for workers to transition into other roles or out of the emergency services workforce

- Organisations should ensure their policies follow a rehabilitation first approach to mental health – aiming to return an individual to either their pre-injury position or supporting their return to another role within the service.
- A program for planning and supporting workers leaving the emergency services should be developed, particularly for those with mental health conditions that carry a significant risk of worsening morbidity.
- Organisations should streamline workers compensation claims determinations and rehabilitation, and ensure staff in workers compensation organisations have appropriate training for managing mental health cases.

Notes on the Terms of Reference

The RANZCP recognises that the groups encompassed in the terms of reference are not homogenous, that each face unique circumstances and issues, which may contribute to a range of physical and mental

health outcomes and that support systems vary across jurisdictions. The RANZCP also recognises the very important contribution of first responders who serve as volunteers, who may not be able to access preparation and support in the same way as professional and staff officers. This submission includes notes on defence and military personnel, including reservists, who face a number of similar risks to emergency service workers.

Mental Health of First Responders, Emergency Service Workers and Volunteers

The mental health of non-operational and operational first responders and emergency service workers can be influenced by a number of factors, including traditional workplace risks such as large workloads, lack of control over work and demanding deadlines and targets (LaMontagne et al., 2007; Cotton et al., 2016). Operational first responders and emergency service workers face unique risks in addition to traditional workplace risks, including repeated exposure to trauma (Cotton et al., 2016). Individuals recruited often have high expectations of their own performance and a low tolerance for failure.

It is important to note that the successful treatment of psychiatric conditions can occur and that self-referral will not necessarily lead to discharge from the service. This perception is a significant barrier to self-referral.

Trauma Exposure

Exposure to trauma or 'critical incidents', such as disasters, interpersonal violence, traffic accidents, and combat, forms an important part of the work of first responders and emergency service personnel. Research on Australian firefighters provides a valuable snapshot of trauma exposure in emergency services. A study on South Australian metropolitan firefighters found that 76% of the workforce reported exposure to 10 or more critical incidents throughout their career, and almost all those involved reported witnessing death on the job (Van Hooff et al., 2018a).

It is important to note that many of those exposed to trauma are expected to react with mild, transient distress that ultimately results in return to normal function (Benedek et al., 2007). Studies suggest that trauma can build resilience, leading to post-traumatic growth (Armstrong et al., 2014). However, exposure to trauma can also result in the onset of, or deterioration of, mental health conditions, which may be immediate or have a delayed onset (Solomon and Mikulincer, 2006; McFarlane, 2010; Varker et al., 2018). The reactions of first responders and emergency services personnel to trauma may vary from the general population, in particular reporting responses such as anger and guilt, rather than fear or horror (Levin et al., 2014; Phoenix Australia, 2013).

In first responders and emergency service personnel it is not simply exposure to a single traumatic event but repeated trauma exposure that results in the neurobiological dysregulation that underpins the emergence of clinical disorder (McFarlane, 2010). Population studies show that the number of trauma exposures increases the risk for post-traumatic stress disorder and other adverse health outcomes (Del Gaizo et al., 2011).

Particularly well studied in this field is post-traumatic stress disorder (PTSD), with systematic reviews of the evidence indicating that emergency service personnel have a significant risk of developing PTSD in the course of their working career (Berger et al., 2012). This is particularly concerning when the numerous physical comorbidities of PTSD are considered, acknowledging that it is a systemic disease that can have a significant impact on a number of areas of life (Yehuda et al., 2015; McFarlane et al., 2017). Approaches to this issue must also consider the issue of suicidal ideation and behaviour with lower levels of mental distress, known as sub-syndromal PTSD. With sub-syndromal PTSD individuals report levels of symptoms that a just below the threshold required to reach the DSM diagnostic criteria.

Sub-syndromal PTSD has been identified as being a significant risk factor for the later emergence of PTSD (Smid et al., 2009).

Emergency personnel who are not necessarily directly exposed to a traumatic situation can experience vicarious trauma (also known as indirect or secondary trauma), which involves witnessing trauma or repeated exposure to another person's trauma. This has been noted in emergency medical dispatchers who take calls from the triple zero hotline (Adams et al., 2015). While further research is required before secondary trauma is fully understood, it is important that it be considered with regard to emergency services personnel and to ensure that treatment and care are appropriately provided.

Psychiatrists are well placed to provide support and expert advice for the management of trauma exposure, and should be involved in the development of initiatives to manage the risks associated with emergency services work. They should seek to understand the values and taskings of the organisations the work with and be prepared to consult with the command structure and insurance arms of those organisations.

Working Conditions and Occupational Stressors

In addition to trauma exposure, first responders and emergency service workers also have to contend with workplace stressors such as long hours, physical exertion, interpersonal conflict and budgetary constraints. These occupational stressors are common in many industries and vocations, however for first responders, these can exacerbate underlying mental health issues and create barriers preventing individuals from seeking or offering help.

Research into Australia police organisations provides a valuable snapshot of some of the occupational stressors faced by emergency workers. An independent review into Victoria Police found leadership behaviours, co-worker interactions, tolerance level for bad behaviours and workload pressures were raised as impacting the mental health of police (Cotton et al., 2016). This is consistent with other research on the police force, which identified a number of occupational stressors, such as work overload, interpersonal stressors, management incompetence and others (Tuckey et al., 2012). An older study further found that policy officers consider general organisational issues to be more stressful that operational pressures (Hart et al., 1994).

These issues appear to be common across many first responder and emergency service worker organisations, with a 2018 report on firefighters in Adelaide identifying similar workplace stressors. Common issues included job skill concerns (83 per cent), co-worker conflict (80.7 per cent), sleep issues (79.7 per cent) and poor health habits (73.9%) (Van Hooff et al., 2018a). This report noted that occupational stress had a strong relationship with psychological distress, although it does not confirm a causative influence. Other research indicates that higher levels of organisational stress can be a significant predictor of PTSD symptoms and PTSD in firefighters (Meyer et al., 2012; Armstrong et al., 2014).

To provide 24-hour service to the community many first responders and emergency services workers are required to work shifts and irregular hours. The fatigue and sleep disturbance associated with shift work gives emergency workers little opportunity to adjust and may negatively influence their mental health. A pilot study on the impact of shift work on paramedics found that Australian paramedics are faced with poor sleep quality, increased levels of fatigue and depression (Sofianopoulos et al., 2011).

There is extensive literature highlighting the mental health consequences of bullying and sexual harassment, and evidence that such behaviours are common in first responder agencies (Larsen et al.,

2016; NTPFES, 2017). A review of Northern Territory Police, Fire and Emergency Services staff found that 60% of respondents had experienced one or more negative behaviours, including bullying, sexual harassment and racial discrimination, within the past two years (NTPFES, 2017). The mental health consequences of bullying and harassment have been well documented in a variety of occupations, clearly demonstrating the need for organisations to more proactively prevent such behaviours, and support those who are targeted by this behaviour (Lynch, 2002).

Additional Factors

Personal background vulnerability – for example psychological risk factors linked with family origin and childhood trauma – may factor in how first responders and emergency service workers manage the stressors and trauma of their roles. An individual's experience of a potentially traumatogenic stressor may vary according to a range of factors including genetics, developmental stage, previous life experiences, cultural beliefs and available social supports (Wilson et al., 2013). Some organisations argue that these factors are well-managed through pre-employment psychological testing. However, reports on the consistency and use of pre-employment testing has varied among organisations (Australian National Audit Office, 2018).

The 2016 review of Victoria Police mental health found that other personal stressors, such as relationship breakdown and family related problems, may be impactful in the mental health of their employees (Cotton et al., 2016). The RANZCP acknowledges that personal stressors can play a significant role in mental health, however, these issues can be difficult to manage from an organisational perspective.

RANZCP members also noted that emergency services personnel often have poor social support once they are no longer operational, either by dint of being on sick leave, restricted duties or medically retired. The police in particular, feel isolated from the community and once they are no longer operational or are retired, often become extremely isolated from community support and the support of colleagues.

Vulnerable Groups of First Responders and Emergency Services Workers

Volunteers and first responders in rural areas require specific consideration, as they may not be included in regular systems and databases, or seen as permanent members of the team. This means volunteers may not be identified for risk of developing mental illness, and may not be supported by standard safeguards employed by first responder and emergency services organisations. Their access to services may also be limited.

A 2015 study found that rural and regional ambulance workers face unique issues, including treating personally-known patients, working alone and long response times. This study also found that rural and regional ambulance personnel experience high levels of fatigue and emotional trauma at work (Pyper and Paterson, 2016) while an earlier study reported increased levels of fatigue and depression, anxiety and stress, and poor quality sleep (Courtney et al., 2013). Rural and remote communities also have a widely acknowledged disadvantage when it comes to accessing mental health services, due to geographical barriers, maldistribution of medical professionals and unique circumstances surrounding stigma in such communities. In particular, access to specialists, such as psychiatrists, may be limited.

Former and Current Defence Force Personnel

As the RANZCP has noted in previous submissions, current and former Defence personnel are subject to a range of risk factors which impact upon their mental health including cumulative exposure to trauma, as well as social and occupational stressors upon transition to civilian life. Accordingly, there are a range of

strategies and commitments to improve the mental health of former and current Defence personnel. The mental health of Australian Defence Force members and veterans has been explored in a previous Senate inquiry, the findings of which may be relevant to the current inquiry (Foreign Affairs, Defence and Trade References Committee, 2016).

While experiences such as witnessing atrocities or accidentally injuring or killing another person can pose the most significant risk (ADF, 2010), it is important to acknowledge the wide range of causes of mental health issues affecting ADF personnel including bullying, harassment and sexual trauma (Surìs et al., 2007; Zinzow et al., 2007). Traumatic combat experiences should therefore be considered within the contexts of both a person's individual risk factors and broader organisational factors that may contribute to mental distress.

The risks associated with traumatic combat experiences do not diminish after discharge from service, with much evidence to support the continuing effect of traumatic stressors on an individual's mental health. PTSD can have a delayed onset with people who coped well at the time of the traumatic event becoming unwell many years later (Solomon and Mikulincer, 2006). As such, the traumatic experiences of military service present a risk factor to personnel not merely during the time of their service but potentially for the rest of their lives. This is of great relevance in planning transitions to retirement and access to treatment after leaving the service. It is common for ex-military personnel to join the various emergency services, both paid and voluntary, upon discharge from the ADF. This raises the risk of further exposure to traumatic experiences and means there may be crossover between the populations discussed in this submission.

In addition to the lingering effects of traumatic combat experiences, veterans and ex-service personnel face other stressors following their service. Difficulties in transitioning to civilian life may relate to social, occupational and/or psychiatric functioning and may be experienced as feelings of not belonging, a factor in the suicidal process (Sher and Braquehais, 2013). A lack of public understanding around the nature of the work demanded of military personnel often results in the alienation of returning personnel who often feel unable to share their experiences with civilians.

With increasing age comes a variety of other risk factors not distinct to veterans and ex-service personnel including the increased probability of physical injuries and other medical comorbidities. The complex interaction between physical and psychiatric comorbidities can play an important role in the course of an illness including its treatment and the path to recovery. In order to better manage these issues, the RANZCP recommends increasing the roles and responsibilities for psychiatrists and clinical experts within the Department of Veterans' Affairs and the Australian Defence Force.

Research on Linkages between Emergency Service Occupations and Incidence of Mental Health Conditions

This submission provides an overview of some of the evidence around different groups of first responder and emergency service occupations, including firefighters, police, paramedics and Defence Force personnel. A number of reviews and studies have been conducted on the occupational health of these professionals, focusing on mental health conditions such as post-traumatic stress disorder (PTSD), anxiety disorder, substance abuse and depression (Van Hooff et al., 2018a; Cotton et al., 2016). These studies, along with workplace claims data, consistently show heightened risks of mental health conditions for first responders, although prevalence rates vary (Gray and Collie, 2017).

Firefighters

A recent study on South Australian metropolitan firefighters found that an estimated 17.1% of the entire metropolitan fire services met criteria for an anxiety, affective or alcohol disorder in the previous 12 months. The highest 12-month disorder group was anxiety disorders, at 12.7%, followed by affective disorders, at 5.7%, and alcohol disorders at 3% (Van Hooff et al., 2018a). Around 10% of the metropolitan firefighters reported suicide ideation in the last 12 months. Moderate psychological distress was reported in 23% of the firefighters, while 10% reported high or very high levels of current psychological distress.

Research indicates that, for firefighters, experiencing multiple sources of trauma is a significant predictor of, and contributor to, PTSD symptoms (Armstrong et al., 2014; Skeffington et al., 2017). Retired firefighters from Fire and Rescue New South Wales had prevalence estimates of PTSD at 18%, depression at 18% and heavy drinking at 7% (Harvey et al., 2016). This study also found the rates of PTSD and depression for current firefighters were 8% and 5% respectively, while 4% reported consumption of more than 42 alcoholic drinks per week.

Police

A review of the mental health of Victoria Police employees, released in August 2017, found that the most common presenting issues for employees seeking help were: personal relationship problems, work trauma, other mental health issues (e.g. depression, other anxiety disorders), anger, alcohol abuse and workplace conflict (Cotton et al., 2016). This review concluded that a prevalence study would be valuable to clarify the extent of mental health and suicide in the Victoria Police.

A recent report on mental health in the Australian Federal Police, conducted by the not-for-profit Phoenix Australia, found that almost 25% of police who responded to the survey reported experiencing moderate to high levels of current mental distress. Of the respondents, 14% reported clinically significant symptoms of depression, 9% reported symptoms consistent with PTSD diagnosis, 6% reported clinically significant anxiety, 9% reported problematic alcohol use and 9% reported suicidal thoughts (Doherty, 2018). These results were reported in media articles, as the report was not widely publically released. A 2012 analysis based on a survey of 631 Australian police officers estimated depression prevalence in police officers as ranging from 37% to 66%, significantly higher than what was found in the above report (Lawson et al., 2012).

Whilst research on Australian police is limited, it must be assumed that mental health problems associated with their work will be similar to overseas police or Australian military cohorts and is therefore considerably higher than civilian rates, under-reported due to stigma and organisational/cultural barriers, and poorly managed within such organisations. Further research is required to better understand the prevalence of mental illness, and the incidence of suicide in police and ex-police.

Paramedics

Research using Victorian compensation claims found that ambulance officers and paramedics have elevated and increasing risks of mental injury when compared to other healthcare workers (Roberts et al., 2015). International studies suggest that ambulance personnel have the highest prevalence of PTSD among all occupational groups of rescuers (Berger et al., 2012). Reasons for this could include that ambulance personnel are exposed to greater pressure and stress at work than other rescue teams (Young and Cooper, 1995), that they respond to more emergency calls (Di Fiorino et al., 2004) and have closer contact with the victims (Jonsson and Segesten, 2004). The RANZCP notes that,

while the above research provides valuable context for Australia, further study on Australian paramedics is required to fully understand the factors at play.

Australian paramedics have reported significantly higher levels of fatigue, depression, anxiety, and stress, and significantly poorer sleep quality than reference samples. Particularly concerning is that over 10% of paramedics reported severe or extremely severe levels of depression. Researchers conclude that paramedic shift workers are at particular risk for increased levels of fatigue and depression (Courtney et al., 2010; Sofianopoulos et al., 2011).

Defence Force Personnel

Research released as part of the Transition and Wellbeing Research Programme found that an estimated 46.4% of ADF members who had transitioned from full-time service within the past five years met 12-month diagnostic criteria for a mental disorder. The report notes that the most common type of disorder for the last 12 months for transitioned ADF was anxiety disorder (37%), followed by affective disorders (23.1%) and alcohol disorders (12.9%) (Van Hooff et al., 2018b). A second study under the Transition and Wellbeing Research Programme found that while self-reported rates of help seeking for a mental health problem are reasonably high, due to attrition at each help seeking stage and variability in the treatment services delivered, approximately a quarter of those with a probable current mental disorder were estimated to have received evidence-based care in the last 12 months. This is an unacceptably low number of transitioned and regular ADF who are receiving appropriate assistance with mental health issues (Forbes et al., 2018).

Evidence provided by the Department of Veteran's Affairs (DVA) to the Foreign Affairs, Defence and Trade References Committee in 2016 indicated that 147,318 veterans with one or more disabilities were supported by the DVA at March 2015. Of these, 49,668 veterans had one or more accepted mental health disability. However, advocacy groups argue that estimates of the number of veterans with service-related mental health problems could be significantly higher, as not all veterans access DVA services or have been allocated a DVA client number (Foreign Affairs, Defence and Trade References Committee, 2016).

Management of Mental Health in First Responder and Emergency Organisations

The management of mental health conditions in first responder and emergency services organisations varies substantially between organisations. This makes it challenging to comprehensively review and comment upon practices in the field. The RANZCP has focused on a number of areas of significant concern below.

Factors Impeding Management of Mental Health Conditions

The prevention and early identification of psychiatric injury is extremely important, and is an area where significant improvements are required in first responder and emergency service organisations. An ANAO audit of mental health care in the Australian Federal Police found that attempts to identify psychiatric injury were limited by a number of barriers, including:

- cultural barriers that reduce the likelihood of AFP employees self-reporting psychiatric injury;
- limited training and support for supervisors in identifying and supporting employees at risk of psychiatric injury; and

- inconsistent delivery and tracking of mandatory mental health assessments and psychiatric debriefs (ANAO, 2018).

It is likely that these barriers are common across a number of emergency and first responder organisations. They reflect a significantly underfunded and uncoordinated approach to employee mental health, and require substantial improvement in order to ensure those who are experiencing or at risk of mental illness have access to the appropriate services. These problems are then exacerbated by a lack of communication between emergency services departments and organisations and their relevant workers' compensation organisations, as well as a lack of coordination between the varying jurisdictions, State and Federal, under which these issues fall. It is clear that State and Federal Governments need to provide a more coordinated system of care for victims of trauma, in particular first responders and emergency services personnel.

The Australian Defence Force Mental Health Prevalence and Wellbeing Study found several barriers impeding care for mental health conditions. Among the respondents, the highest rated barrier to personnel seeking help for a stress-related, emotional, mental health or family problem in the ADF was the concern that seeking help would reduce their deployability and lead to discharge (36.9%), whereas the highest perceived stigma was that people would treat them differently (27.6%) and that seeking care would harm their careers (26.9%) (ADF, 2010). It is worth noting that the use of individuals external to the organisation may be counterproductive in initial management of mental health, and while peer support may be an effective methodology, the RANZCP encourages an increase in the roles and responsibilities of psychiatrists within these organisations. For psychiatrists and other health professionals, an advanced understanding of the context and pressure faced by first responders is highly valued.

Stigma is noted to be a highly prevalent barrier to seeking help. A number of reviews, including the review of the mental health and wellbeing of Victoria Police employees, have found organisational issues with delayed and avoided help-seeking due to stigma (ANAO, 2018; Cotton et al., 2016). The RANZCP believes that measures to reduce stigma are a key part of improving help-seeking and early intervention rates.

During this consultation, many psychiatrists raised issues with the management of mental health conditions by insurance and compensation agencies. Problems highlighted included organisational conflicts of interest, frequent changes of staff, requiring patients to provide the same information on multiple occasions, at times in very agitating, confrontational and aggressive environments. While the large majority of independent medical examiners are both professional and appropriate, and thereby of real assistance to the patients, there have been a very small number who have been aggressive, bullying, dismissive, denigrating and stigmatising. At times these interviews have left patients acutely distressed with acute exacerbation of their conditions. This can have long term impacts on recovery (Grant et al., 2014). There is a need to streamline and improve these processes, which too often are based on claim rejection as a first response and allow perpetration of an administrative treadmill which produces secondary psychological injury. Greater oversight would assist in this field.

Medical professionals need to be aware of the unique contributing factors, circumstances and presentations of first responders and emergency service workers. Specialists involved should ensure they understand the values, traditions and tasking of the organisations they work with. A number of evidence based resources are available, including the Expert Guidelines for the diagnosis and treatment of PTSD in emergency service workers (Harvey et al., 2015). It is important that first responders and emergency service workers can access specialist medical professionals who understand their unique

experiences, either through lived experience or through experience working with the specific population group. This can be challenging in rural and remote communities, where there are fewer psychiatrists available at all, let alone those who specialise in veteran, military and first responder mental health. The RANZCP has been working to build networks to support psychiatrists who specialise in this area of practice, and recently established a Military and Veteran Mental Health Network within the College.

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