Senate Education and Employment References Committee Inquiry into the Mental Health Conditions Experienced By First Responders

Australian Psychological Society Response

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Summary and recommendations

The nature of the mental health conditions which affect the first responder workforce (FRW) are well described in the pertinent literature. They primarily relate to the affective, anxiety and stress-related disorders as defined by the DSM-5/ICD-10 classificatory systems. Dysregulated posttraumatic anger is also a significant problem for the FRW.

The causes of these conditions are less well documented, but can be explained by pre-employment factors, the nature of the first responder role and post-event environment support factors. Where members of the FRW feel cared for, they are capable of greater levels of coping with role demands. The appreciation of this continues to be patchy within and across systems.

The available data indicates that the overall risk of the FRW developing a TRMHC is twice that of the general population. For some FRW members, the risk of injury is greater again. Importantly, populations at risk for occupational traumatisation have higher TRMHC prevalence rates, greater symptom intensity and duration and loss of function.

There are clear opportunities for improvement related to the early detection of emerging mental health issues and TRMHCs and the need for a greater focus on improving the organisational culture of FROs. This will involve a shift from the managers and peers of the FRW viewing the emergence of the signs and symptoms of TRMHCs with fear to acting with openness and support, such that TRMHCs are understood as an occupational risk in the FRW and not a personal weakness.

Many opportunities for improvement in the conduct of workers compensation schemes as they apply to the FRW present themselves. They relate to the adoption of a less adversarial approach to dealing with worker's compensation claims. It is also important that Workers Compensation Schemes take every effort to untie compensation entitlements from the need for treatment. It is highly advisable that all jurisdiction investigate the benefits of the early introduction of intervention of treatment provided by peer acknowledged expert treaters

Various FRO management and workplace cultural factors impede the management of mental health conditions in the FRW. The APS believes that where these factors are in play this reflect the past or present absence of a comprehensive workplace mental health strategy. Pragmatic programmatic interventions likely to promote wellbeing and good mental health in the workplace are well known and need to be introduced.

It is also important that government give due consideration to the operation of employment schemes that will offer future employment possibilities to members of the

FRW who can no longer work in either the same job or with the same employer. Advances will ensue from top-to-bottom reviews of RTW arrangements within schemes and the role of expert RTW consultants.

There is much to be gained through the sharing of knowledge among FROs across Australia. There is a need for information, practical recommendations and clear paths forward.

It is critical that this collaboration occurs at state and federal levels and is led by appropriate state, territory and national first responder peak councils involving representatives from all areas of the sector.

It is important that the role of FRW ESOs may play in assisting retired members of the FRW is investigated.

Both increased and redirected resource allocation is required so that the mental health issues identified in this Inquiry are addressed.

It is also important that government look to (a) influence employers to take more account of the effect of work on the families of the FRW (e.g., by increasing the amount of "family leave" available to workers and making internal and EAP counselling services available to the families of workers) and (b) introduce or expand the provisions of workers compensation schemes to fund familial and other supports to FRW partners and families.

Recommendations

The APS recommends that the Senate conveys to, and assertively follows up with, all Australian State, Territory and Federal governments to:

1. Address the inconsistent recognition of the importance of FROs fully exercising their workplace responsibilities to care for the mental health of the FRW.

2. More assertively and promptly address the problem of workplace psychological injury via evidence-based preventive, care and treatment interventions.

3. Review the efficiency and effectiveness of FRO capacities for detecting the early warning signs of mental ill health.

4. Influence FRO management to implement best-practice organisational and treatment interventions. These should be stepped or nested according to individual need.

5. Amend workers compensation systems across Australia to untie worker's compensation entitlements from their treatment entitlements.

6. Recognition of the role of FRO middle-management in driving workplace cultural reform. This will involve a shift on the part of FROs to a new paradigm of understanding.

7. Address the Australia-wide impediments to effective occupational rehabilitation schemes in the sector identified in this Inquiry

8. Increase the sharing of knowledge among FROs across Australia.

9. Recognise of the important role ESOs may play in assisting retired members of the FRW.

10. Increase and redirected resource allocation that seeks to address the FRW mental health issues.

Introduction

The Australian Psychological Society (APS) welcomes the opportunity to provide a submission to the Australian Parliament Joint Committee Inquiry into the role of commonwealth, state and territory governments in addressing the high rates of mental health conditions experienced by first responders, emergency service workers and volunteers (hereafter referred to as the First Responder Workforce or FRW).

The APS is the largest professional organisation for psychologists in Australia representing over 24,000 members, of whom a small, but significant, number deliver evidence-based psychological services to the first responder, emergency service and volunteer workforce as sole providers or as members of a service provider entity.

This submission is based on feedback sought from those members. It addresses the Inquiry's Terms of Reference (TsoR), where relevant to psychology and member feedback.

Response to Inquiry Terms of Reference

The range of occupations that may be involved in the FRW, tasks in which they may be involved and situations to which they may respond are many and varied. It is, consequently, not possible in this submission to fully describe who and what may be involved in the delivery of a "first response".

Importantly, while this submission typically illustrates its observations by reference to the experience of police, ambulance and fire service personnel as archetypes of the FRW, where there is vocational exposure to potentially traumatising events (PTEs) involving actual or implied threat and harm on an individual or mass-scale (as per natural disasters and human-caused catastrophes) basis, the risk of psychological injury extends beyond such archetypes. Thus, the observations and recommendations of this submission apply to less visible and infrequently commented upon members of the FRW [e.g., child protection workers, accident (e.g., transport accident) or crime scene rectification and investigation personnel] and those who might not ordinarily be recognised for their repeated and aversive occupational traumatisation (e.g., hospital emergency department, coronial investigation, court support and forensic pathology staff).

Inquiry ToR A. The nature and underlying causes of mental health conditions experienced by first responders, emergency service workers and volunteers

The nature of the mental health conditions experienced by FRWs (hereafter referred to as trauma-related mental health conditions or TRMHCs) has been relatively well established across a range of government and government-funded reports, research studies and

academic review papers. The underlying causes of those conditions are many and have a complex causal impact. Each are now described.

There are mental health conditions that affect the FRW (e.g., the psychoses and personality disorders) but have little direct association with the stressors associated with employment experiences. The expression of these conditions may be exacerbated by occupational and traumatic stress and the needs of those suffering such conditions require an appropriate organisational response. They, however are not the subject of this submission.

The nature of the mental health conditions experienced by first responder workforce

The TRMHCs with the greatest prevalence among individuals vocationally exposed to PTEs are the affective, anxiety and stress-related disorders as defined by the DSM-5/ICD-10 classificatory systems. Dysregulated posttraumatic anger is also a significant, yet unrecognised, problem for the FRW.

It is important to note that these TRMHCs typically occur comorbidly for the FRW. Thus, while PTSD is understood to be causally linked to posttraumatic mood, anxiety and anger problems (Issakidis, Sanderson, Corry, Andrews & Lapsley, 2004; The Rand Corporation, 2008), each can pre-morbidly, peri-traumatically or posttraumatically increase the impact of the others.

Underlying causes of those mental health conditions

To understand TRMHCs, it is necessary to consider not only the nature of the events to which individuals are exposed, but also the resources and deficits they bring to recovery and the context in which they do so (Keane, 1998). Thus, the occurrence of TRMHCs in the FRW may be understood as the result of three, interrelated, sets of psycho-social risk factors: (1) pre-employment factors or enduring individual characteristics of the individual, (2) the nature of the first responder role-event related factors and (3) post-event environment support factors (see Vogt, King & King, 2014).

Pre-employment factors - enduring individual characteristics

Pre-event factors can make an important contribution to the development of TRMHCs among the FRW. Early-life and maturational experiences, cognitive/affective vulnerabilities, pre-existing mental health conditions, personality style and the rigidity of beliefs and moral attitudes have each been noted for their association with development of TRMHCs (see Forbes, Creamer, Hawthorne, Allen & McHugh, 2003; Forbes et al., 2008; Janoff-Bulman, 1989, 1992).

It is beyond the scope of employing organisations to fully prevent the potential impact of such characteristics on the mental health of the FRW. This underscores the importance of purpose-designed employment and ongoing mental health screening processes in FRW organisations. This is particularly so in less professionalised organisations or organisations that incorporate large numbers of non-professional and/or volunteer members - for example, rural and regional fire and emergency service organisations.

The nature of the first responder role - event related factors

Event-related factors make the most visible contribution to the incidence of TRMHCs in the FRW. The FRW has a known higher frequency of exposure to PTEs and while it is estimated that 65 per cent of the community are exposed to one or more PTEs across their lifetime (Creamer, Burgess & McFarlane, 2001), the FRW is known to have much higher rates of exposure to PTEs and segments of it (e.g., police, ambulance and fire services) have a 100 per cent career-wise probability of exposure to PTEs. Higher rates of exposure to PTEs are associated with greater levels of mental ill health (Joyce et al., 2016).

Not all events confer the same degree of risk for the development of TRMHCs, however, and the FRW is not only occupationally more exposed to PTEs, but is further at risk due to cumulative exposure to extreme PTEs (ePTEs); for example, crime-related injury and death, graphic, aversive details of crime (e.g., child abuse), collecting human remains, terrorist attack and crime scene investigation. Such ePTEs have the potential to result in adverse psychological reactions involving anger, disgust, extreme fear and horror. This is especially so where the events concerned are perceived to be associated with gross human violation(s) that are repugnant, malevolent or immoral. Events with these characteristics have the potential to foster alterations in perceptions of self, others and the world (see Frame, 2015; Janoff-Bulman, 1989, 1992) and can be particularly problematic for the FRW units that deal with them.

Segments of FRW with significant exposure to e-PTEs are known to have higher rates of psychological injury (e.g., as measured by the rate of workcover claims, absenteeism and presenteeism and the development of TRMHCs (Marmar et al., 2001). Police units that deal with reprehensible human behaviour, like those that investigate sexual offences against children or homicide, experience increased rates of TRMHCs (see Hartley, Violanti, Sarkisian, Andrew & Burchfield, 2013) and are the archetypal risk group for the development of occupation-related TRMHCs.

Importantly, however, such groups, rarely, if ever, present for mental health assistance after their initial experience of a PTE. This is yet to be definitively explained, but the FRW is noted for its mental toughness and hardiness (resilience) and it is the insidious effect of

this accumulated exposure to PTEs and ePTEs that creates a potential vulnerability for the development of TRMHCs. A linear trauma-dose response relationship does not exist (Marmar et al., 2001) and the tipping point events that kindle TRMHCs are often, ironically, insignificant, but emphasise the slow buildup involved in the emergence of TRMHCs in the FRW.

The role of the FRW often, depending on the Service implicated, involves exposure to range of job requirements and experiences that are non-traumatic in nature, but likely to increase the risk of developing a TRMHC. Their impact on the FRW is again well illustrated by the experience of police. Policing requires the undertaking of a range of challenging tasks that involve exposure to significant emotional distress in others - for instance, in the conduct of "mental health checks" and door-stop "bad news" delivery police undertake after deadly events (e.g., due to crime, industrial and road traffic accidents and disasters).

The FRW is also heavily affected by day-to-day job characteristics. These include workload (e.g., long hours, night-shift work and overtime without breaks) and the inherent administrative burden involved. The importance of these factors has been observed in reviews (see the VicPol MH Review) and guidelines; for instance, the Australian Centre for Posttraumatic Mental Health (ACPMH) (now Phoenix Australia) in its 2013 *Australian Guidelines for the Treatment of Adult with Acute Stress Disorder and Posttraumatic Stress Disorder* observes that PTSD research suggests that, compared to the experience of isolated PTEs, "non-event characteristics" may be more related to the development of TRMHCs. In in effect the dissonance between the high-impact traumatic nature and bureaucratic burden of "the job", often creates a jarring meaning-banality conflict in the first responder role.

Further to this, is the impact of injury and threat(s) (to self, family and colleagues) experienced by those delivering a first response and the role complication that exposes segments of the FRW to differential levels of danger. For example, police are more exposed to the threat of death than military personnel, but have a lesser legitimacy of self-defence and experience significant loss and bereavement where colleagues are injured "on the job" and are no longer able to work or have died.

Additionally, there is sometimes a counterintuitive lack of public empathy for the FRW role: the public may depend on it; its reactions, however, can involve extreme expectations, criticism, indifference and, sometimes, hostility. Illustrative of this, are the need for workers compensation authority (e.g., WorkSafe Victoria) campaigns against occupational violence in the health care industry and the 2018 Victorian Government

decision to introduce legislation protecting ambulance workers from occupational violence at the hands of service recipients and bystanders.

Additionally, there is the significant impact of the vicissitudes of the criminal justice system on the FRW. Illustrative of this, first responders have reported that they are often subjected in court environments to aggressive, threatening and insulting behaviour by offenders and their associates and behaviour from lawyers that they have described as professionally disrespectful and at times, bordering on unethical. This is well illustrated by the experience of Child Protection Practitioners (CPPs). Importantly, the Victorian Ombudsman's (2009) *Investigation into the Victorian Department of Health and Human Services Child Protection Program* identified CPPs' experiences with the legal system as a prominent reason for low career retention. Similarly, the 2012 Victorian Government report *Protecting Victoria's Vulnerable Children Inquiry* (Cummins, Scott & Scales, 2012) cited court processes as one of the greatest difficulties CPPs experience in their work, while the 2018 *Victorian Auditor General's Report Maintaining the Mental Health of Child Protection Practitioners* noted the problems posed for CPPs by the extreme administrative burden related to court appearances.

Post-event environment - support factors

The third influence on the mental health of the FRW, is the role of the organisation. Although historically less well appreciated for its impact, the organisation is a pivotal determinant of FRW mental health.

The importance of social support to posttraumatic recovery has long been acknowledged (see Bryant et al., 2016) and the fundamental role of the organisation in promoting or undercutting mental health has begun to be increasingly acknowledged in a recent range of inquiries and reviews of the impact of stress and traumatic stress on the mental health of the FRW. Illustrative of this, the recent review of Victoria Police Mental Health (Cotton, Hogan, Bull & Lynch, 2016) identified low levels of mental health literacy in the organisation and an urgent need to implement an organisation-wide, comprehensive program to address its absence.

Such inquiries and reviews point to the absence of a comprehensive understanding of what mediates and moderates mental health in the FRW, unhelpful assumptions about, and attitudes and behaviours toward, those displaying signs and symptoms of work-related stress and traumatic stress are prone to develop. These beliefs and behaviours commonly revolve around ideas of threat by contagion, nuisance and failure and are held by not only peers, but also organisational senior office holders and leaders. Unchecked, this can result in externalised stigmatisation (i.e., shaming).

In the face of such shortcomings in understanding, and cumulative stress and trauma-induced personal beliefs (e.g., "humans are rotten at the core"), those affected by their workplace experiences are susceptible to internalised stigmatisation (i.e., misplaced guilt) characterised by ideas that "it is weak to seek assistance … I cannot expect help … no one cares". Although it is inherently difficult to discern which occurs first, it is well established in research and reviews that the behaviour of the organisation, where lacking, exacerbates the injury sustained.

Unaddressed, such beliefs, assumptions, attitudes and behaviours can result in harmful cultural characteristics within organisations. These characteristics can include marginalisation, interpersonal conflict and subtle and overt forms of vertical and horizontal bullying. All can lead to a mismatch between the worker's deep-seated sense of vocation and perception of the organisation's lack of care for their wellbeing, such that they experience a palpable sense of loss (e.g., in capacities, career and identity) and anger. Illustrative of this, injured members of the FRW routinely lament the lack of contact from their managers post their taking leave as part of a workcover claim. At best, such impacts are associated with degraded operational performance (e.g., as measured by mistakes and inattentional misjudgments), presenteeism and dissociation (see van der hart, Wang & Solomon, 2012) and, although hitherto largely unrecognised, a liability to react inappropriately in anger due to meaning related and angry PTSD (see McHugh, 2018). At worst, they can lead to "management action" (i.e., workplace discipline) that is misplaced and mistimed and further promotes the perception that "the organisation does not care" (see ToR C for further comment).

Inquiry ToR A: Summary and APS recommendations

The nature of the TRMHCs that affect the FRW are well described in the pertinent literature. The causal factors for these conditions are less well documented but can be explained by pre-employment factors, the nature of the first responder role and post-event environment support factors. The impact of pre-event and trauma-related characteristics are least amenable to change and, in some instances, beyond the scope of FRO to moderate. However, the possibly most important predictor of, and the causal factor most open to change, workplace mental health is the behaviour of the employing organisation toward its workforce. Where members of the FRW feel cared for, they are capable of greater levels of coping. The appreciation of this continues to be patchy within and across systems.

The APS recommends that this Senate Inquiry conveys to, and assertively follows up with all governments across Australia to address the inconsistent recognition by FROs of the

importance of them fully exercising their workplace responsibilities to care for the mental health of the FRW.

Inquiry ToR B. Research identifying linkages between first responder and emergency service occupations, and the incidence of mental health conditions

Over the last decade, many reports, surveys, studies, meta-analyses, systematic reviews and guidelines have identified a link between membership of the FRW and the incidence of TRMHCs. Although military personnel are not explicitly the focus of this submission (and yet often play an important role in the first response to natural disasters and emergencies), this link is best established in that population.

Illustrative of this, various Australian studies of military and veteran populations have estimated the prevalence of current (i.e., as reported within the last 12 months) PTSD at between 8.1 per cent and 11.4 per cent (Grayson, Dobson & Marshall, 1998; O'Toole et al., 1996), with lifetime rates approximately double those figures. This compares to a general community current prevalence rate of around 4.4 per cent for current and 7.2 per cent for lifetime PTSD (Mills et al., 2011).

Definitive prevalence estimates for such conditions in the FRW are yet to be agreed, however, and disorder rates vary greatly between jurisdictions and service type(s) and on account of the investigative methodology employed. Using the example of PTSD, surveys of Australian police have placed its prevalence at between six and 32 per cent (Davidson et al., 2006). In comparison, US studies report police PTSD rates spanning 12 to 35 per cent (Mann & Neece, 1990) and Dutch police have been identified as having a seven per cent disorder prevalence, with 34 per cent reporting sub-threshold PTSD (Carlier, Lambert & Gersens, 1997). Some studies suggest PTSD is most common among ambulance personnel (Berger et al., 2012), while others have identified police as having the greatest disorder rates (Meffert at al., 2008).

Successive studies and expert commentaries (e.g., the Australian Guidelines on the Diagnosis and Treatment of Post-traumatic Stress disorder in Emergency Service Workers, 2015) have emphasised that a range of TRMHCs can occur in the FRW conditional on the cumulative exposure to PTEs. As previously observed in relation to ToR A (p 5), the mental health conditions that impact most upon FRW are the affective, anxiety and stress-related disorders as defined by the DSM-5/ICD-10 classificatory systems. Dysregulated posttraumatic anger is also a significant problem in the FRW.

The available data suggests that, hierarchically, the most common TRMHCs for Australian FRWs are likely to be:

1. mood (and most commonly major depressive) disorder
2. anxiety disorders
3. acute stress disorder and
4. PTSD.

Other common psychological issues and conditions that affect the FRW workforce can include sleep and addictive disorders (especially substance abuse and gambling disorders - see Harvey et al., 2016). As previously observed dysregulated anger is under-acknowledged and very powerful response to stress and traumatic stress (McHugh, 2018).

Precise risk estimates of such disorders are typically yet to be agreed. Although prevalence may vary across services, the available evidence suggests approximately 10 per cent of first responders will meet the criteria for a diagnosis of PTSD (Phoenix, 2013). Less than the estimated PTSD incidence rate for past and current serving military personnel, it is approximately double the rate applicable to members of the general community exposed to PTE's. Exceptions to this include refugees exposed to atrocities or torture, prisoners of war and rape victims (58%), who have the highest rates of PTSD (Phoenix, 2013). Importantly, populations at risk for occupational traumatisation are not only known to have higher TRMHC prevalence rates, but also greater symptom intensity and duration and loss of function. Again, police with PTSD are an archetypal illustration of this (Mayhew, 2001).

Inquiry ToR B: Summary and APS recommendations

The available data indicates that the overall risk of members of the FRW developing a TRMHC is twice that of the general population and some FRW members are particularly at risk for injury. Examples of those most occupationally at risk, include CPPs and police in specialist investigative units (e.g., those related to child sexual abuse or homicide). Importantly, populations at risk for occupational traumatisation have higher TRMHC prevalence rates, greater symptom intensity and duration and loss of function.

The APS recommends that this Senate Inquiry urges all governments across Australia act to cause FROs to more assertively and promptly address the links between workplace exposure to PTEs and psychological injury.

Inquiry ToR C. Management of mental health conditions in first responder and emergency services organisations, factors that may impede adequate management of mental health within the workplace and opportunities for improvement

The following issues were identified for comment by this Inquiry as part of this third ToR. The APS offers the following specific comments in relation to them.

i.   Reporting of mental health conditions

Accurate and timely identification and reporting of the signs and symptoms of TRMHCs among the FRW, and subsequent comprehensive assessment of them, is critical to the wellbeing of the FRW and the prevention of mental ill health within it. Effective reporting has several enabling characteristics. First, TRMHCs and emerging mental health issues are freely communicated by the FRW without fear of adverse consequences and/or reaction(s) from peers or management. This is effectively a non-stigmatising "two-way street" that permits and endorses bottom up and top down identification of target phenomena.

The second essential characteristic of effective reporting is the early identification and reporting of TRMHCs or emerging mental health issues. This is supported by a range of Australian government reviews and inquiries over the last decade that have observed this early intervention failure across jurisdictions and services (e.g., The 2012 *Western Australian Parliamentary Inquiry into Emergency Staff and Volunteers* and 2016 *Victoria Police Mental Health Review* (VicPol MH Review; Cotton, Hogan, Bull & Lynch, 2016). Despite the findings of such reviews and inquiries, feedback from members in the field, indicates that the early signs of psychological injury are still not being detected or recognised and early intervention is, therefore, not being made appropriately available.

Finally, triage of what is reported - that enables prompt referral for either peer interventions (see ToR C IV, pp 17-18) or expert assessment of the need for intervention - is a fundamental plank in the prevention of problem chronicity. There is, unfortunately, evidence that triage which leads to intervention within FROs (e.g., in welfare units) or outside them is often neither adequate in nature nor leads to satisfactory outcomes (see the next subsection of this TOR for further comment).

Opportunities for improvement

Various organisational factors impede the reporting of TRMHCs or the symptoms thereof in the FRW. There are clear opportunities for improvement related to the early detection of emerging mental health issues and TRMHCs. These include the:

1. establishment by FROs of an occupational health and safety minimum KPI data that addresses the gaps in existing data sets, and is transparent and meaningful, administratively not burdensome and adopts a risk management approach,

2. establishment of a standardised Commonwealth-wide FRO data set that enables benchmarking with capacity for individual jurisdictions to self-identify their position on an associated "league table" and

3. analysis of the available data to establish trends, intervention efficacy and the need for additional intervention programs.

ii Specialised occupational mental health support and treatment services

It is critical that FROs take an active interest in the mental health of their workforce(s) through the establishment of interwoven specialised occupational mental health support and treatment services. Both are predicated upon the above-mentioned organisational capacity to identify the need for intervention.

Beyond its role in identification, organisation-driven specialised occupational mental health support in the workplace is a first critical plank in maintaining the mental health of the FRW. The effect of the failure of management to do so has often been commented upon by inquiries into the mental health of the FRW cited in this submission [e.g., the Western Australian Parliamentary (2012) *Inquiry into The Toll of Trauma on Western Australian Emergency Staff and Volunteers* and the Victorian Ombudsman's (2016) *Investigation into the management of complex workers compensation claims and WorkSafe oversight*].

While there is evidence FRO leaders are attempting to respond more effectively to the mental health needs of the FRW [e.g., Victoria Police adopted all the recommendations of the VicPol MH Review (Cotton et al., 2016) in its 2017-2020 Mental Health Plan], across Australia members of the APS continue to report there is a disconnection between executive level behaviour and the implementation of support at the "coalface", resulting in inconsistent, piecemeal or reactive responses. This is exemplified by evidence of maladministration of mental health problems in the regional, rural and remote FRW (i.e., in the toxic behaviour of local branch/division/station management) and the notable regional variation that exists in approaches to mental health issues (e.g., as measured by industrial disputes around local management behaviour and increased rates of worker's compensation claims in those locations).

Complicating this, APS members report that there continues to be limited access to trained staff who understand the culture of the FRO and have the authority or capacity to intervene productively (see ToR C, IV, pp 17-18 for further comment).

As observed across this submission, the real or perceived failure of the FRO to fulfill its duty of care to address the consequences of occupational exposure to trauma, the FRW is liable to conclude (erroneously or not) that FROs are incapable of understanding or caring for them.

Evidence-based psychology interventions have a paramount role in the recovery from traumatisation and prevention of TRMHCs. The availability of specialised mental health support and treatment services is, hence, a second critical factor in the maintenance of the health and wellbeing of the FRW.

Exemplifying this, PTSD is prolonged by the absence of effective treatment (Friedman & Pitman, 2007, Friedman, 2011). This was illustrated some time ago by Kessler and associates (1995) in their analysis of the US National Comorbidity Survey data. They showed that the (median) time to recovery (i.e., the point at which 50% of cases recover), was 36 months for those who had sought professional assistance, but 64 months for those who had not.

There are effective treatments for TRMHCs. This is again well illustrated by reference to PTSD, where substantial level one evidence [i.e., that generated by randomised controlled trials) (RCTs) has shown that Trauma-focused Cognitive Behavioural Therapy (TF-CBT), especially where it has imaginal and in vivo exposure at its core, is the first line treatment for PTSD (see Joyce et al., 2016). In contrast, pharmacological therapy operates as an adjunctive treatment and is more likely to result in symptom re-emergence on its discontinuation (Lancaster et al., 2016).

Unfortunately, it is apparent that evidence-based psychological practice (EBPP) is neither sufficiently taken up by the FRW nor promoted across the sector by FROs. There are many supply and demand issues that explain this.

On the "supply side", there is a shortage of practitioners willing to, or capable of, driving effective treatment via EBPP. Estimates of those who apply best practice in the treatment of TRMHCs like PTSD are as low as 20% (e.g., Becker, 2004) and have been resistant to change over a long period of time. Simultaneously, while individual and institutional (e.g., hospital) providers claim to provide EBPP, it is sometimes apparent that they either do not actually possess this knowledge or are mistaken as to what constitutes effective treatment. There is, hence, often a gap between rhetoric and practice. If members of the FRW are to receive first line EBPP, those who seek to deliver efficacious trauma-focused psychological treatment must be able to demonstrate the capacity/competency - e.g., via certification or accreditation that transparently demonstrates objective evidence of capacity and highest quality outcomes.

There are several "demand side" reasons why this failure occurs. First there is the effect of worker-experienced stigmatisation associated with treatment seeking, client skepticism and interfering anger (see Becker, Zayfert & Anderson, 2004; Cotton et al., 2016; Hodson, McFarlane, Van Hooff & Davies, 2011; Stephenson & Chemtob, 2000).

Although anecdotal in nature, there is evidence contemporary members of the FRW are much more aware of their workers compensation entitlements. Senior members of the FRW and the industrial bodies in the space have reported that there is an increased tendency for current-day, early-career, first responders to make earlier workers compensation claims for injury compared to their predecessors.

Importantly, there does not appear to be a commensurate recognition among the FRW of the need to seek early psychological intervention. Thus, those who would benefit from treatment, do not seek that treatment, thereby resulting in many FRW members needlessly being off work, unproductive and becoming psychologically unwell. This is a widespread scenario across all jurisdictions and services, and is a well-recognised, circular problem.

Although there is increasing recognition of the need for earlier and more effective treatment intervention, the time taken by injured FRW members to seek psychological treatment after the experience of a workplace psychological injury has historically averaged between seven and 10 years. This and the failure of treaters and services to provide EBPP has meant long delays in obtaining effective treatment which inevitably add to the burden of TRMHCs.

Given the well-documented evidence (Black, 2008; Harvey, Henderson, Lelliot & Hotopf, 2009) and expert consensus statements (e.g., Royal Australian College of Physicians, 2011), about the deleterious health and mental health consequences of work loss (see ToR c iii for further comment), it is important that this cycle is broken. The obligation for breaking this impasse logically and operationally belongs with FROs.

Opportunities for improvement

Encouragingly, there has recently been some positive developments; for example, in the aforementioned adoption by VicPol of the entirety of the recommendations of the VicPol MH Review (Cotton et al., 2016) and the development of the *Expert Guidelines on the Diagnosis and Treatment of Post-traumatic Stress Disorder in Emergency Services* (Harvey et al., 2015) and its accompanying *Clinician Summary* (Harvey, Bryant & Forbes, 2018). This should not mask the need for a greater focus on improving the organisational culture of FROs. This will involve a shift from the managers and peers of the FRW viewing the emergence of the signs and symptoms of TRMHCs with fear to acting with openness and

support, such that TRMHCs are understood as an occupational risk in the FRW and not a personal weakness. APS members have described this as workplace with an ethos of "look after yourself, look after your mates".

Effective change will, at a minimum, involve a "supply side" focus that proactively:

- enhances the capacity of FRO wellbeing services to assist the FRW to optimally manage its reactions to workplace stressors and prevent the development of TRMHCs
- increases access to accredited health providers and programs with objectively proven capacity to work with the unique aspects of FROs and the FRW in mind - APS members have observed that in house units are seen by workers as inherently compromised by their position within the organisation, while EAPs are often described by injured workers as staffed by junior practitioners, practitioners who are not skilled or, ironically, have little understanding of the first responder context or are unable to provide guidance around what might effectively be done about the presenting problem, especially where it involves untoward management action) and
- facilitates collaboration between employers and compensation authorities and their authorised agents with advisory and peak professional bodies to address the uptake of EBPP by practitioners in the field, and the promotion of such practices by practitioners by FROs.

iii.   Workers' compensation

The APS believes that too often, workers compensation schemes act as illness schemes, the agents who administer them act in adversarial manner and result in "compo only" disputes and settlements.

Various reviews of the conduct of workers compensation schemes have been conducted across Australia in the last decade and support this view. These reviews have inevitably commented on issues pertinent to the FRW. They have identified a range of shortcomings in the treatment of injured FRW personnel under compensation systems. For example, the Victorian Ombudsman's 2016 *Investigation into the management of complex workers compensation claims and WorkSafe oversight*, observed the:

- unnecessary claim disputation that was doomed to failure, and ultimately did not succeed, but occurred over extended periods of time up to an including quasi-legal fora
- prejudicial (via ignoring or omitting) use of evidence and quotations from the reports of Independent Medical examiners (IMEs) in its justifications for decisions
- selective use of IME opinions, that suggested fishing expeditions, when the overwhelming evidence obtained was to the contrary
- reaching of incorrect decisions based on the facts

- posing of leading questions of IMEs (to obtain preferred answers, thus the rendering those experts non-independent)
- impact of these practices on the worker's recovery and
- more-than-occasional description by claimants of the behaviour of the insurer as bullying.

Such workers compensation scheme reviews have also noted the failure of these schemes to achieve their stated objectives; for example, in the Return to Work (RTW) of injured workers. This is further expanded upon under ToR C, v (pp 21-22).

Opportunities for improvement

Various workers compensation system factors impede the management of mental health conditions in the FRW. Several opportunities for improvement in the conduct of workers compensation schemes as they apply to the FRW present themselves.

The first relates to the gains that would be made for all parties (worker, employer and insurer) by the adoption of a less adversarial approach to dealing with worker's compensation claims. The comments of the Victoria Ombudsman in relation to the plight of CPPPs particular pertinent here and it is strongly advisable that her findings and recommendations be applied as a template for all Australian Workers Compensation Systems.

It is also important that Workers Compensation Schemes take every effort to untie compensation entitlements from the need for treatment. It is highly advisable that all jurisdiction investigate the benefits of introducing "pre-emptive legislation" that makes treatment irrespective of claim acceptance - a good example of this relates to the Department of Veterans Affairs (DVA) non-prior approval for psychology.

An early intervention approach to managing workers claims is essential where there is an accepted primary or secondary injury mental health condition. An example of this exists in Victoria, in a police mental health early intervention pilot around psychological injuries, involving VicPol, the WorkSafe authorised insurance agent and WorkSafe itself. Known as the *Victoria Police Pending Claim Intervention Project*, this project is aimed at ensuring the injured worker is steered towards receiving timely and appropriate treatment under the care of their treating health practitioner. It has achieved strong results in the year since its introduction.

Members have stressed the importance of members of the FRW who are psychologically impacted by TRMHCs or their symptoms having access to psychological interventions provided by expert treaters. As part of this, it is vital that employers and insurers develop

commonly shared lists of practitioners who have demonstrated expertise in the use of EBBP for TRMHCs. It is also important that workers compensation insurers develop incentives (including differential remuneration scales and accredited training) for practitioners who are prepared to: (a) base their work with the FRW on ESPPs for TRMHCs and (b) engage in peer consultation and review around this work.

iv.   Improving workplace culture and management practices

As emphasised throughout this submission, the conduct of FRO management is primary in promoting and maintaining the wellbeing and effective performance of the FRW. Fundamental to this, is the capacity of FROs to recognise and better understand-stress and trauma-related reactions. As noted above in ToR C (i) (pp 12-13), this requires FROs to be openly interested in the mental health of their workforce via regular, periodic and ad hoc forms of enquiry and vigorously encourage help seeking and better-utilise specialised occupational and mental health support and treatment services.

To do this, FRO management must address workplace management and cultural practices via workplace mental health and mental illness prevention, wellbeing and safety programs. It must also apply the applicable knowledge by "skilling" management at all levels from organisational leaders to senior office holders, peers and employed mental health professionals. Important developments with the capacity to benefit the field include the following interventions.

Mental Health Literacy. Defined as "knowledge and beliefs about mental disorders which aid their recognition, management or prevention, mental health literacy (MHL) includes the ability to recognise specific disorders; knowing how to seek mental health information; knowledge of risk factors and causes, of self-treatments, and of professional help available; and attitudes that promote recognition and appropriate help-seeking". It aims to increase knowledge about physical health, illnesses, and treatments (see Jorm et al., 1997)

Trauma Informed Care (TIC). A trauma-informed workplace creates a place of safety for those who have been exposed to trauma. It responds on every level with an understanding of the effects of stress and trauma and recognises the potential for traumatisation to occur. Workplaces that practice TIC are aware of, and sensitive to, the dynamics of trauma-exposure, irrespective of whether it is known to exist in individual cases. A range of private and public health authorities and advisory bodies (e.g., Phoenix Australia), have endorsed TIC and it has been adopted by government departments (e.g., the Victorian Departments of Health and Human Services and Juvenile Justice) as a means for maintaining the health and wellbeing of workers.

Psychological First Aid (PFA)/Skills for Psychological Recovery (SPR). The use of such interventions is based on the understanding that those exposed to a PTE may experience a range of early reactions (physical, psychological, emotional and behavioural) which are natural and understandable, but may subside with time and that helping people to identify their immediate needs and strengths and abilities to meet these needs can build their capacity to recover (APS, 2013).

The aims of PFA are to promote recovery by assisting people to: (1) feel safe, (2) remain connected to others, (3) be calm and hopeful, (4) access physical, emotional and social support and (5) help themselves. Although there is little level one research (RCT) evidence demonstrating the efficacy of PFA, it is considered an evidence-informed intervention by experts (e.g., Bisson & Lewis, 2009; Dieltjens, Moonens, Van Praet, De Buck & Vandekerckhove, 2014; and Shultz & Forbes, 2014). The status of PFA is well established in guidelines by a variety of important local and international organisations that operate in the field (e.g., the APS/Australian Red Cross, 2013).

A similar, but modular, post incident intervention is the Skills for Psychological Recovery (SPR) Program. It utilises skills-building components from mental health treatment that have been found helpful in a variety of post-trauma situations SPR is appropriate for developmental levels across the lifespan, can be titrated for audience exposure and capacity and is culturally informed. It has been trialed for first responders by VicPol with success (see Cotton et al., 2016).

Use of peer support. The provision of PFA by supervised personal support officers (PSOs) to first responders following a PTE is a useful, low-cost intervention. The availability of well-trained PSOs can aid first responders to cope better with work-related and other stressors and is well-supported by expert bodies (Creamer et al., 2012). Members have emphasised the key role of PSOs, but have also stressed the need for consistency of approach (and especially PSOs knowing when to refer on to expert assessors and treaters).

It is important that, where implemented, these programs:

- adopt an early intervention approach to care that makes available a nested continuum of interventions ranging from education to treatment
- longitudinally monitor (e.g., for 12 months post-event) well-being and the impact of the health interventions implemented, in a format that is built into the culture of the organisation and is not excessively time consuming and
- accommodate the nature of the FRW workforce culture. Members have observed that understanding the cultural strengths and weaknesses of FROs and the FRW is critical in

that it facilitates engagement and reduces barriers to intervention. Demonstrable cultural competency requires that those concerned with the mental health of first responders understand that there are (at least) three aspects of FRO culture that require recognition; that is, the

- operational ethos of FROs - which involves values of integrity, duty to the public and a willingness to place oneself in difficult situations to assist others. This is commonly what draws people to vocations in the sector(s),
- commitment to the "team" of the FRW. This represents an operational bond that makes the work based on the teams and protects the safety of those "in the job" and
- (as a product of the first two factors) existence of the FRW and their families as a culturally distinct community with specific psychological needs.

Opportunities for improvement

Various FRO management and workplace cultural factors impede the management of mental health conditions in the FRW. The APS believes that where these factors are in play this reflect the past or present absence of a comprehensive workplace mental health strategy.

Pragmatic programmatic interventions likely to promote wellbeing and good mental health in the workplace are well known. Proven examples include:

1. Mental Health Literacy
2. Trauma Informed Care
3. Psychological First Aid and
4. Skills for Psychological Recovery.

Beyond such programs and packages, it is important that other localised and organisational/unit-level interventions are also reviewed for their applicability in "high stress" areas of work. Important examples capable of providing protection, building resilience, sustainability and facilitating and promoting engagement include:

- professional (psychological) supervision and peer mentoring
- rotations and sabbaticals
- ongoing training around trauma reactions and
- increased availability of peer support.

Given the FRW reports a disconnection between senior management behaviour and the expressed values of the organisation, it is important that a whole-of-organisation is

adopted to improved conflict management and resolution (especially in regional and remote areas) and building cohesive teams. This is about percolation of message from organisational top to bottom and applies to FRO leaders, senior office holders, peers and mental professional staff.

Members of the APS have observed that to prevent many of the issues identified across this submission, much needs to be done on addressing the psychosocial risk factors that make workplaces psychologically safe. They have indicated the need for supportive leadership training and more focus on resilient leadership and organisations. In practical terms they have stated that at a management level this is about being able and willing to have difficult conversations regarding inappropriate behaviour and mental health in the workplace - including designing and committing to meaningful and sustained return to work programs (many members commented on failed RTW attempts driven by managerial indifference and sometimes near-hostility to the worker on return).

v.   Occupational function and return-to-work arrangements

APS members have observed that if an individual is on workers compensation leave, it is critical that they participate in a graduated return to work program (GRTWP) in an alternative position within their service, or alternatively, in an organisation orchestrated volunteer role outside their organisation. Extended periods spent on workers compensation often leads to increased severity of symptoms, greater difficulties in returning the individual back to work diminished work prospects.

Under the various worker's compensation schemes across Australia, there are four broad RTW outcomes:

1. *Same job, same employer*

2. *Same job, different employer*

3. *Different job, same employer and*

4. *Different job, different employer*

Although workers may have a demonstrable work capacity, often it is not possible for them to successfully RTW in the same job. Less commonly, it may not be possible for others to return to the same employer.

APS members have indicated that if a suitable alternative position within the service is not available for the individual, it is recommended that the employee be provided with a 15-hour Career Transition/Outplacement Program to expedite and increase their chances of, re-employment. The program would consist of career counselling, resume development,

job search skills training, interview skills training, and weekly ongoing job-application support, and implemented at the earliest time approved by the treating mental health professional(s).

Injury Management Consultants be contracted to create, facilitate, and monitor graduated return to work programs (GRTWPs) for personnel with a psychological condition. The GRTWPs could involve the individual returning to their previous position, or an alternative position, as per the recommendation made by an assessing mental health professional. The involvement of a psychologist injury management consultant is likely to increase the success of the GRTWP.

This is consistent with the findings of the aforementioned literature and the successive national and international reviews on the health benefits of work. That literature details the deleterious effects of the loss of the welling and mental health of individuals.

Notwithstanding this consensus, there are system-limiting practices that militate against the worker. For example, WorkSafe agents in Victoria provide no incentive to agents to focus on RTW post six months from the date of injury. This is a serious absence given many claims by the FRW involve long periods of incapacity.

Opportunities for improvement

There are various impediments to effective occupational rehabilitation schemes in the sector. These need to be addressed as opportunities for change.

Advances will ensue from top-to-bottom reviews of RTW arrangements within schemes and the role of expert RTW consultants (the quality of these services is known to be very variable and is illustrated by the experience of an ex-police officer who was given advice by a rehabilitation consultant that he consider the role of undertaker for a future job, given his policing experience).

It is also important that government give due consideration to the operation of employment schemes that will offer future employment possibilities to members of the FRW who can no longer work in either the same job or with the same employer. An example of this exists in the Prime Minister's Employment Scheme for younger veterans.

vi.   Collaboration between first responder and emergency services organisations

In making this this submission, the APS wishes to emphasise the fractured nature of the FRO response to the mental health needs of the FRW across Australia. The situation as it has existed to this time is one where there is little sharing of knowledge across jurisdictions, a failure of organisations to learn from each other and to implement best

practice. There is also the absence of a clear, visible forum for the sharing of knowledge that creates the potential for needless "reinventing of the wheel".

Opportunities for improvement

The APS believes that there is much to be gained through the sharing of knowledge among FROs across Australia. There is a need for information, practical recommendations and clear paths forward contained in various inquiries, reviews and resources.

It is important that the findings and lessons of inquiries and reviews like those cited throughout this submission be shared and where practical implemented across jurisdictions.

Such collaboration should not be limited to FROs. It is important that where possible, that collaboration with industrial bodies (associations/unions and employer groups) and peak professional bodies occur so that a "whole of system" approach can be taken in relation to the welfare of the FRW.

It is crucially important that this collaboration occurs at state and federal levels and is led by appropriate state, territory and national first responder peak councils involving representatives from all areas of the sector.

vii.   post-retirement mental health support services

Given the typically strong sense of vocation with members of the FRW engage in their work, when they prematurely terminate their service due to ill-health retirement, this can be especially problematic for them. For many, this separation from vocation represents a loss of a way of life, identity and purpose.

The emotions of loss, guilt, shame, sadness and anger commonly accompany such retirement scenarios. At a practical level, early retirement also results in the loss of the grounding life structure and the intense professional and inter-personal relationships which routinely develop in first responder community.

This has, traditionally, not been sufficiently-well recognised, in the transitioning arrangements that apply across to the sector. Ill-health retirement by use of fitness for duty assessment has in the past been criticised in some in some jurisdictions in has (e.g., in Victoria, prior to the 2017 VicPol Review). Those criticisms have included the haste, arbitrariness and timing of those assessments, the failure to allow retirement processes of appropriate duration and the failure to celebrate the careers and achievements of the retiring officer(s).

In response to such shortcomings members and the reviews involved have advocated for changes of approach to psychological injury and specifically, avoiding medical retirement if/when possible, and giving consideration given to different roles the individual could do within the organisation (see ToR vi immediately above). For the reasons described there, where this is not possible it is important that transition members of the FRW al reasonable assistances for transition to other work or other stages of life where work is not possible

It is important that ex-service organisations (ESOs) be established or supported to play a role in this space, where they are established. In the ex-military/veteran world, ESOs exist in abundant forms; for example, in state councils that are auspiced by DVA and comprise all such registered ESOs (e.g., the RSL). Equivalent ESOs of well-respected organisations such as the RSL and Legacy are typically lacking in the First Responder sector.

Opportunities for improvement

The Victorian Retired Police Support Organisation (VRPSO) is a FRW post retirement support organisations. It offers a range of services to retired officers experiencing of mental health issues. It describes these as:

- initial support and assistance to colleagues regarding work, family and personal issues

- referrals to appropriate health and support services if necessary and

- follow-up support and facilitate linkages to services, as requested

As far as the APS is aware, it is the only volunteer peer support program of its kind for former police in Australia.

It is important that the role of FRW ESOs may play in assisting retired members of the FRW is investigated. The VPRSO serves a model for the development of such organisations.

viii.   Resource allocation.

The human and economic costs of mental health injuries to the FRW are considerable. This is extremely ironic given the public importance of the role of responders in the good functioning of society.

Not acting to address these costs will be a continued failure on the part of government.

It is important to acknowledge, however, that direct and indirect expenditure by FROs around the mental health of the FRW is already significant. This is well illustrated by reference to the cost of the workers compensation premiums that organisations must bear across Australia.

Resource allocation is, therefore, not only about increased funding, but the efficacy and efficacy of that expenditure.

<u>Opportunities for improvement</u>

Both increased and redirected resource allocation is required so that the mental health issues identified in this Inquiry are addressed. Such funding would ideally be (better) targeted to the provision of a range of important enhancements of existing arrangements. Possibilities include:

1. Expert and professional advice around implementation of improvements and systems for assessing ongoing improvement. As observed above, there have been more-than-enough inquiries, reviews and research papers to indicate the path forward. It is now time for government to cause the sector to move to an implementation (and analysis) phase of effort.

2. Review of current RTW schemes. To the present time, such schemes have not delivered the anticipated outcomes. It is important that they be thoroughly reviewed across Australia for their limits and that all such limits are removed in accordance with best practice.

3. The increased fiscal recognition of the role of retired peer support organisations and other ESOs.

4. The consolidation and extension of peak councils in order that they become more transparently and authentically focused on outcomes

Inquiry ToR C: Summary and APS recommendations

The APS believes there are clear opportunities for better management of TRMHCs and associated issues in the FRW. It recommends that the Senate conveys to, and assertively follows up with, all Australian state and federal governments to emphasise the importance of:

1. FROs reviewing the efficiency and effectiveness of their capacities for detecting the early warning signs of mental ill health. FRO reviews should explore the:

   a) universal implementation across Australian FROs of best practice detection and identification of the signs and symptoms of mental ill health among the FRW

   b) ongoing monitoring of occupational health and safety data by FROs around effectiveness, by the augmentation of existing OH&S (e.g., via risk management) systems with the capacity to compare outcomes across organisations, systems and Commonwealth via a common minimum dataset

c) establishment of a shared de-identified Commonwealth-wide FRO performance benchmarking tool, with the capacity for individual jurisdictions to identify their position on an associated "league table" and

d) annual reporting on the resultant data in a transparent and meaningful, but not administratively burdensome manner, that is oriented toward systemic improvement in outcomes of the FRW.

2. Working with FRO management to implement best-practice organisational and treatment interventions. These should be stepped or nested according to individual need and include the:

   a) enhanced capacity of FRO wellbeing services to assist the FRW to optimally manage its reactions to workplace stressors and prevent the development of TRMHCs

   b) increased access to accredited health providers and programs with objectively proven capacity to work with the unique aspects of FROs and the FRW in mind and

   c) increased utilisation of expert advisory bodies and mental health professions (e.g., APS) to promote and measure the uptake of EBPP.

3. State and federal workers compensation systems across Australia untying worker's compensation entitlements from their treatment entitlements by

   a) adopting an early intervention approach to treatment in claims where a mental health condition is accepted as a primary or secondary injury

   b) developing pre-emptive legislation that unties treatment intervention from the claim acceptance process

   c) developing commonly shared lists of practitioners with demonstrated expertise in the use of EBBP for TRMHCs

   d) increasing and encouraging access to evidence established expert psychological treaters and

   e) developing differential remuneration scales for mental health practitioners who are: (a) prepared to base their work with the FRW on EBBP for TRMHCS and (b) engage in peer consultation and quality assurance procedures that reinforce this.

4. Recognition of the role of FRO middle-management in driving workplace cultural reform. This will involve a shift on the part of FROs to a paradigm of understanding and action that:

   a) an early intervention approach is applied at all possible points in maintaining the mental health of the FRW and reducing the threat of the development of mental health problems

   b) help seeking is encouraged from day one of the careers of the FRW as an organisational expectation

c) introducing comprehensive workplace mental health strategies as part of the core business of organisations, that involve pragmatic programmatic interventions likely to promote wellbeing and good mental health in the workplace like: Mental Health Literacy, Trauma Informed Care, Psychological First Aid and Skills for Psychological Recovery

d) organisational/unit-level interventions are also introduced in areas of known high stress, including: professional (psychological) supervision and peer mentoring, rotations and sabbaticals, ongoing training around trauma reactions and increased availability of peer support and a whole-of-organisation is adopted to improved conflict management and resolution and building cohesive teams

e) ongoing monitoring of processes and training/supervision/mentoring programs are all important in terms of protection, building resilience, sustainability and facilitating and promoting engagement with appropriate referrals and

f) use of expert bodies and professional peak bodies to design and deliver ongoing training that is reviewed for its effectiveness.

5. Addressing the Australia-wide impediments to effective occupational rehabilitation schemes in the sector identified in this Inquiry. Advances will ensue from top-to-bottom reviews of RTW arrangements within schemes and the role of expert RTW consultants. It is also important that government give due consideration to the operation of employment schemes that will offer future employment possibilities to members of the FRW who can no longer work in either the same job or with the same employer.

6. Sharing of knowledge among FROs across Australia. There is a need for information, practical recommendations and clear paths forward contained within various inquiries, reviews and resources. It is important that the findings and lessons of inquiries and reviews like those cited throughout this submission be shared and where practical implemented across jurisdictions.

It is important that where possible, that collaboration with industrial bodies (associations/unions and employer groups) and peak professional bodies occur so that a "whole of system" approach can be taken in relation to the welfare of the FRW.

It is crucially important that this collaboration occurs at state and federal levels and is led by appropriate state, territory and national first responder peak councils involving representatives from all areas of the sector.

7. Recognition of the important role ESOs may play in assisting retired members of the FRW.

8. Increased and redirected resource allocation that seeks to address the FRW mental health issues identified in this Inquiry. Possibilities include:

   a) expert and professional advice around implementation of improvements and systems for assessing ongoing improvement

   b) review of current RTW schemes

   c) increased fiscal recognition of the role of retired peer support organisations and other ESOs and

   d) the consolidation and extension of peak councils and think tanks in order that FROs become more transparently and authentically focused on outcomes.

Inquiry ToR D. Other matters

A glaring omission across justifications and services in most of the workplace arrangements that apply to the FRW, is the failure to consider the impact of the FRW experience on their families and loved ones. This, is again ironic considering government is their employer and has a nation-leading, visible duty of care toward its employees.

Inquiry ToR D: Summary and recommendations

It is important that government look to (a) influence employers to take more account of the effect of work on the families of the FRW (e.g., by increasing the amount of "family leave" available to workers and making internal and EAP counselling services available to the families of workers) and (b) introduce or expand the provisions of workers compensation schemes to fund familial and other supports to partners and families.

Precedents for both exist in the Department of Veterans affairs and Department of Defence environments and some accident and workers compensation schemes (e.g., those in Victoria).

Conclusion

The APS welcomes the opportunity to submit to this important Senate Inquiry. It believes that the impact of work on the mental health of the FRWs is a significant problem that until recently has been insufficiently recognised.

Over the last 10 years, there have been many Federal and State Government Inquiries across Australia. These Inquiries mirror the findings of the pertinent literature and emphasise the critical role of government in promoting the mental health of the FRW.

The APS contends that it is now a time for action. The problems facing the FRW are well understood, and if these issues are not addressed, they will continue to impact significantly on the FRW and compromise their role and function. This represents a deep irony given the public importance of the role they play in the good functioning of society

In urging government action around mental health in the first responder sector, this submission identifies the need for:

1. Early identification of the emerging signs of mental illness.

2. Triage of need and onward referral to specialist mental health providers.

3. Workers compensation schemes to more effectively address the FRW's treatment needs.

4. Programs of workplace education and skill development capable of percolating fully across the workforce and recognition of middle management's role in relation to it.

5. Removal of impediments to effective occupational rehabilitation schemes in the sector.

6. Increased leadership and co-ordination of effort across the sector.

7. Recognition of the importance of ESOs in assisting retired members of the FRW.

8. Increased and redirected resource allocation and

9. Increased recognition by all parties of the effect of first responder work on FRW families.

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