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Committee Secretary
Senate Education and Employment Committees
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Dear Secretary,

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.

First I must apologise that the enquiry has only been brought to my attention today. I am therefore not in a position to prepare a detailed submission in the time I have available. Nevertheless, given the extent of my professional involvement with police and ambulance officers I have thought it appropriate to submit considerations on which I have reflected, as well as extensively informally researched, for over thirty-four years.

Background

I have been involved as a clinician with first responders and emergency service workers through initial engagement by the NSW Police in 1984. Since then I have treated and/or advocated for police and emergency services personnel in Victoria, New South Wales, Queensland, Tasmania, the Northern Territory and Federal Police.

My first involvement was through the homicide unit and victims and families of victims of violent crime. Work extended to ambulance personnel in 1989 following the Kempsey bus crash. I have been in contact with senior ranks of assistant commissioners and above, to the present.

Subsequently, I have worked with police from U.K., Germany, Canada, Netherlands, Belgium, U.S.A., New Zealand, Australia and others, where they have been involved in peacekeeping including in Timor Leste, Lebanon, Rwanda, Srebrenica, Afghanistan, inter alia. I therefore have a working knowledge of similarities and differences.

I regard myself as a specialist in chronic mental trauma and resulting post-traumatic stress disorder; not to be conflated with the many other similar diagnoses which lack the repetitive and iterative nature by which first responders and emergency service workers seem to acquire their poor mental health. My thesis was on the recovery of family members of homicide victims.

My second area is mental disabilities and their treatment and rehabilitation; including genetic, congenital, developmental, acquired, disease related, deteriorating and terminal.

For additional reference I been involved in organisational culture change as a consultant to Deloitte and Pricewaterhouse Coopers (PwC) on government and mining and bank sector organisational development projects throughout the 1990s and have run a large humanitarian project across the Middle East with responsibility for mental health of one and a half million refugees, employing some four hundred staff and seven thousand volunteers, covering six countries and eighty refugee camps.

Mental Health Conditions

This is such a broad concept as to require further analysis. It includes genetic conditions, brain injury, mental illness, psychological injury, etc. These all have different geneses and contribute to poor mental wellbeing in different and potentially cumulative ways. They are not all preventable or amenable to interventions in the workplace.

Only for example, it is my experience that at least 25% of my police clients and 10% of other emergency personnel have degrees of executive dysfunction; such as, extreme and not always societal held or necessarily rational views of right and wrong, radical deductionism and limited fluid (inductive) reasoning, critical thinking difficulties, difficulties with self-awareness or insight, perseveration - inability to transition away from an event, task, enquiry, investigation, or even when concluded or quite dysfunctional, narrow social skills, limited communication styles, inter alia. This is roughly between ten and twenty-five times higher than in the general population.

Political context

While probably always the case, over the period of my involvement, the apparent increasing politicisation of police with interference in service strategies, Heightened policing on limited areas

(drugs), campaigns (law and order), wedge politics (anti-terrorism) has changed the nature of policing and its internal management. Top levels of police services attend to the needs of political employers with little internally evident consideration or resistance to negative affects on personnel or even at times the community requirements. Whether these reflect the needs of the police and the communities or are only serving political strategies is for others to determine. The current medicinal cannabis policy is a case in point where a few heart breaking television shows have swayed politicians, and emergency personnel have to explain the difference to teenagers. Services personnel face the paradox of budget constraints versus political mission spread and community expectation for service.

Community

The community has become largely estranged from its police, different to other emergency service personnel. While nurses, paramedics and fire fighters interact and socialise across the community they are ubiquitously seen as heroes. Few people see police in such a light resulting in increasing self and other isolation among police.

Many police will not disclose their occupations to none police friends and associates. There is relationship forming and marriage between police. Socialising is almost exclusively within police. It is reportedly impossible for them to disclose their work without being made to listen to a litany of complaints and often accusations of wrong doing.

Media reports of police are almost always portrayed in the negative, even when apprehending an offender and even after heinous crimes. Police 'reality' television universally shows police as strong, aggressive, fighting, smashing in doors, and manhandling. I am unaware of any that show the exhaustion of shift work, the boredom or drudgery, the paperwork, pacifying domestic violence situations, caring for and nurturing people dying in accidents, delivering death messages, and what it may be really like attending in horrific circumstances and having to remain in that situation, on occasion for hours.

Anti-violence campaigns for paramedics, ambulance officers, nurses, and aged care workers have been launched in Victoria, South Australia and Tasmania, to my knowledge. In each of these police have been excluded. It is my perception that police are far more likely to be a target of violence than any other emergency personnel. Can it be expected of police that they should be targets for violence?

Organisational culture

It is understood that these are large complex organisations with significant mission spreads. What

is perhaps noteworthy and seen in all emergency organisations at different times, is the absence of effective delegation of and accountability for the care of personnel to line managers. This is probably most apparent in the waves of disenchantment that permeate from time to time. It is appreciated that no organisation is immune but the lack of attention to preempt, the belated attention if any to address, and if so then the pauce nature of subsequent interventions seem inadequate to typical organisational demands.

It is difficult to conclude that personnel are seen as a priority. After direct conversations at senior levels, over the past eighteen months, it has been difficult to develop confidence in a comprehensive approach of senior personnel to all the intersecting elements of an effective organisation which includes personnel in acute roles.

Personnel

Different roles attract different types of people but they do attract types. Not all are necessarily suited to the role but may nevertheless be perceived as useful by management for attributes that may not be helpful to colleagues or the community. It is acknowledged that there are some roles where, for example, a more or less nurturing or aggressive demeanour may be an advantage. There seems little consideration of the essential management oversight necessary or intrinsic self control, nor the history of the individual.

There have been known cases of perhaps petitio principii, where a paramedic returning to work after the death of their partner and children in a fatal motor vehicle crash was stationed at a highway location known for its motor fatalities. Within days they went on sick leave and without returning left the service. A female victim of grooming and sexual abuse was accepted into police and is working in police child protection. A male with multiple allegations of sexual harassment, abuse and one of rape is investigating sexual assaults. Internal investigations have been delegated to the target of complaints in at least two cases. There are many more such incidents.

The most common theme and regarded as significant by all mental health professionals involved is the detrimental nature of shift work. Only in the past weeks has a known member who worked four day shifts, then with no break moving to four night shifts, the first day working eighteen hours and expecting to be off for four days, been sent a revised roster, with no break, immediately recommencing with five nights. The person broke down in the station and was transported to hospital. Similar cases are encountered every few months. While it is appreciated that there are always operational requirements, the apparent absence of an even medium term view with expected risk management for sickness is a concern. The resulting effect is of even less reliability of personnel.

As a reflection, in Australia most fortunately there have been no non-natural emergencies warranting this type of pressure on personnel. Having worked widely in theatres of conflict and a volunteer at Darwin hospital during the repatriation of Bali bombing burn victims, appointed to monitor medical staff, even they were stood down after designated hours. That emergency service personnel are regularly placed under such pressure seems inappropriate management at best and perhaps unconscionable.

The extensive use of neuroleptic medication and alcohol, as a symptom of appropriate functioning among personnel is at levels which must be a concern. In social groups of different emergency personnel, the only group with some apparent immunity seem to be fire fighters. This may be the nature of the person of the job. At a station barbecue a self-disclosing senior sergeant asked who was not on medication and two people responded.

Remedial strategies to supplement medical treatment are invisible. Authoritarian policies of operational effectiveness or discharge serve neither personnel nor the community. The lack of short term alternative roles ensures burn out. There are many police who serve their entire time in communications, community engagement, watch houses, traffic and other less stressful roles. Police returning from mental injury need these as intermediate return to work posts. A degree of nepotism and favouritism of appointments to such roles has also been observed over many years.

Alternative employment opportunities in public services could be provided and seen as a natural segue with benefits intact.

Recruitment and training

Recruitment of police while having some discernment seems limited in its veracity. Psychometric instruments are seen as infallible. The expertise of some practitioners, other than for generic assessment and superficial understanding is not present. Opposite interpretations of the identical information by psychiatrists, police doctors, police psychologists in different roles and others shows little consistency. Bulk assessment services while widely used in government are as yet not supported by any published longitudinal study. Having more direct observation of recruits by experienced personnel may be one answer. The present mentoring approach is reported as a vehicle for, at times, developing inappropriate conduct.

Initial training seems lacking in many areas but particularly in relation to informing reasonable longevity in such emotionally and demanding roles. Notwithstanding the frequent rhetoric,

management training and effectiveness in staff management and the importance of mental wellbeing has not observably improved over thirty years across Eastern states. While so called resilience training is in vogue, the evidence for it is not well established. Just because we may have identified a shortcoming does not mean we have the solution.

Personnel pay is another issue. Many emergency service personnel become dependent on high income relative to their ability to earn in other work. Police refer to this as 'golden handcuffs.' Alternatives are hard to come by seeing many burned out people staying beyond their effective period and unable to move. There seem few emergency personnel in any service that retire on a high with an optimistic sense of future. Many in the last years before retirement are observed to be holding on at lowest levels of performance to the detriment of everyone else and with deteriorating mental health. This issue starts much earlier.

Workers compensation insurance and injury management

This submission would not be complete without comment on such a poorly documented procedure with such importance. Across Australia I have never, notwithstanding many attempts over many years, been able to obtain or even derive a process as to how emergency personnel with mental injuries progress through rehabilitation, in the particular state. Claims are approved and then rejected and vice versa. They are challenged by services without submissions attracting censure from reviewing authorities. In one case one member has had five insurance case managers and eleven organisation injury managers over eight months.

Typically it seems that mental injuries are treated like physical injuries even when the person is so incapacitated as to be unable to conduct a conversation. The immediate expediency and cost effectiveness of this process seems to be at the fore with no broader view of additional costs should the rehabilitation go awry. Due to different insurers, changes in medical personnel, injury management staff changes and even less obvious reasons, one client was directed to attend six psychiatrists, two police doctors and two police psychologists in addition to me and his private psychiatrist. As a result his return to duties was delayed for two years until a police doctor actively intervened. Another senior officer in a different state is in a similar situation where return was delayed for three years after recommendation, after which his substantive position was no longer available so he has been 'working from home' with occasional forays to clear emails for a further two years. Being close to retirement, it is unlikely anything will progress. His salary alone over this period would amount to over one million dollars. The additional detriment to his mental health has been significant.

Reports are requested and disregarded. Recommendations for return or further time off are

rejected without reason. Pressure is applied to the person to return or not return. Confidential information is publicised across the service. Ancillary organisation staff are tasked to become involved with no understanding as to why and seemingly random individuals also become involved. Any organisational process has been opaque.

Mental injury and illness

There are limited acceptable diagnoses for compensable mental injury. The most usual is post-traumatic stress disorder. In Australia we have guidelines for treatment and even specialist guidelines for police. These have been secondary research derived, that is, from literature. There are few contributors to these who have worked clinically with emergency personnel to even any extent and none discernible to any great extent. While some have primary research experience, this is significantly different from large numbers of clinical interventions with individuals.

Emergency personnel responses to workplace difficulties are conflated with the mostly military and sexual abuse literature. Typically insurers request details of the 'trigger' event with little appreciation of cumulative effects of trauma. No such diagnosis exists even though informally discussed for decades.

Having worked in conflicts (Afghanistan, Middle East, Cambodia) with civilians, military and international police, as well as emergency services for many years, it is my view there is a substantial difference between both the nature of the experience leading to the mental illness and the responses. Regurgitating tried and failed approaches with emergency personnel is unhelpful.

In over thirty years of practice there has not been a week when a new treatment for PTSD is not announced, following research. Often there are multiple advisories per day. These have varied from sweat lodges and trauma focused therapies such as CBT and EMDR to currently in vogue, again, 3,4-Methylenedioxymethamphetamine (MDMA) or Ecstasy. It has run the gamut of neck injections to LSD. This suggests that we are still less than as effective as we would like in its treatment. The prevention of PTSD and other emergency personnel related mental ill health is therefore essential to the extent possible. I believe there are many inexpensive but significant changes available that can mitigate emergency personnel difficulties and improve their metal wellbeing.

I greatly appreciate the committees time. I would welcome the opportunity to further contribute if appropriate.

Yours sincerely,

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