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Introduction:

I am a consultant psychiatrist working in private practice. My specialist qualification is the Fellowship of the Royal Australian and New Zealand College of Psychiatrists. I am a life member of AMSUS, the Association of Military Surgeons of the US. I am a member of the International Society for Traumatic Stress Studies.

The rate of mental health conditions such as Posttraumatic Stress Disorder is broadly proportional to the exposure to traumatic experiences. The most significant factor is the number and severity of these traumatic experiences. The second most significant factor is the management of people after they have had such experiences. Poor support and isolation if not outright aggression and intimidation will significantly aggravate these conditions. There are a number other factors which are important; including effective training, effective leadership, physical fitness, having a clear mission and positive community support are all important. However, In terms of the relative contribution to the production and perpetuation of psychiatric syndromes are less significant than the actual traumatic experiences.

In terms of a systemic response, a process whereby the exposure to traumatic experiences is better mediated is the first priority. The second priority is the effective management after such exposure and particularly effective treatment once these conditions start to develop.

The conditions are varied. Posttraumatic Stress Disorder has been given much of the attention but it is not the only condition that is generated by such exposure to trauma. A range of anxiety and depressive disorders are also common. These conditions often have a major impact on the families.

My expertise is as a clinician and not in research. However, I worked in this area for many years after my military service. I have studied the available publications and attended a range of conferences and presentations, both in Australia and from overseas.

Restructure of exposure in emergency services:

There is a need for these services to consider a serious restructuring and accept that exposure to traumatic experiences is an integral part of their employment. While good training, social support and preparation can improve their resilience, there is a limit that anyone can take on. The emergency services need to have a more active and definite plan to rotate staff and to limit their exposure. In addition, the reality is that training is not always as

effective as it should be, and the social support to the emergency services personnel and their families is often barely adequate, if not poor.

I note that it is common for ex-military personnel to often join the various emergency services both paid and voluntary, after discharge from the Defence Force. Ex-defence Force personnel often have an underlying level of training that is in many aspects parallel to the emergency services, including driving and the maintenance of vehicles; the use and maintenance of radios; and working in teams. The Australian Defence Force personnel are familiar with concepts of command and control that make them very suitable in their skill set to be in the emergency services. However, this raises the risk of further exposure to traumatic experiences.

I consider that the normal process is for most emergency services personnel who are working operationally will be exposed to traumatic experiences. Many in the professional emergency services, police, fire, ambulance, will experience an accumulation of traumatic stressors over time. Overwhelming traumatic events may still occur even on a once only occasion, particularly the more severe experiences.

Emergency services personnel often have poor support from the general community, poor understanding from their command and poor support from their ultimate employers, the various state, territory and Federal governments.

There is a pressing need for all emergency services to look at ways of restructuring the amount of exposure and to improve the level of support and understanding that is given to their operational personnel. This may need to include consideration of significant limitations on the number of years and the intensity of experience in operational employment. Ideally, this means that there should be an active program of rotating staff.

Response by the agencies and their workers compensation bodies:

Once off work due to conditions such as Posttraumatic Stress Disorder, anxiety and depression many patients from the emergency services are often ignored, harassed and stigmatised by some of their colleagues, and certainly by some of their hierarchy. The reaction to the diagnosis of Posttraumatic Stress Disorder seems to be akin to the reaction that you would expect on hearing that the patients have a contagious virus.

The ambulance services are supposed to look after people, but also are notorious for poor management of their own staff who become patients with psychiatric illnesses such as Posttraumatic Stress Disorder, anxiety and depression.

One of the problem areas of the emergency services personnel is their management by various WorkCover, Comcare and similar insurance type agencies that manage the workers compensation aspects once they have been disabled to any extent.

These organisations have a number of problems. They have frequent changes of staff and this frequent change of case managers causes increasing distress to the patients with chronic

psychiatric conditions. These patients are often required to provide the same information on multiple times, often in a very agitating, confrontational and aggressive environment.

One component of this is the role of the independent medical examiner which is an issue not just in psychiatry.

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. At times it seems that is convenient for the various government agencies and departments to choose independent medical examiners who will be likely to cause such aggravation and such negativity. This small group of medical professionals and the case managers and administrators who choose such aggressive and denigrating assessments is an embarrassment to the profession. It is clear that our patients are well aware of what is happening, but are too distressed to be able to do much about this in most cases.

The comment about the independent medical examiners at times also relates to the attitude and behaviour of the staff of the different organisations. While many of the staff are as helpful as they can be and are professional and of real assistance to the patients, there have been some staff who have been aggressive, bullying, dismissive, denigrating and/or stigmatising. Emergency services personnel with significant psychiatric condition such as PTSD, anxiety and depression often have difficulty in coping with this.

Social isolation:

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.

There has been some moves in Victoria to try to look at developing parallel organisations to the ex-service organisations. There is a desperate need to address on a social level and community level, the severe isolation of many of the retired and injured ex-emergency services personnel.

Many of these injured and retired ex-emergency services personnel will seek a quiet environment in which to live and avoid much of the general community. They therefore have a tendency to move to more remote and rural environments. This gives them some peace. It also leaves them more isolated from social support and adequate treatment facilities.

The isolation of these emergency personnel reminds us that the problem of rural healthcare remains unresolved. I am aware of the recommendation of using online and tele-health, but it is a second-best solution. These are difficult people to engage; police in particular have a background where they do not easily form therapeutic relationships. I am also aware of the research in the USA, indicating that a number of veterans do not access the Internet. Also I

am aware of the experience of many patients who have accessed some of the emergency hotlines only to be bitterly disappointed with their lack of understanding of such specific conditions as Posttraumatic Stress Disorder in emergency services personnel.

The nature of chronic Posttraumatic Stress Disorder is that it is chronic and is unlikely to ever fully resolve. Therefore the emergency services agencies and departments and their workers compensation agencies that talk of goals which will facilitate treatment completion shows a complete lack of understanding of these conditions. If this lack of support and understanding is displayed by the staff to the emergency services personnel with such conditions as Posttraumatic Stress Disorder, this will clearly aggravate their sense of isolation and place them under additional stress. It is important that staff who administer these cases have a realistic and practical understanding of these conditions.

The first and primary aim of management is to keep the patient alive and also be aware of the conditions that may aggravate their Posttraumatic Stress Disorder. The aim is also therefore to minimise the risk of harm to other people. I would note that many police and military and ex-military patients with chronic Posttraumatic Stress Disorder have been very agitated and irritable, particularly when additional stresses are placed on them.

Limitations of available treatment services:

One of my most persisting concerns in this region in which I work has been the serious limitation in the availability of specialist psychiatrists. This limitation is worse in the country areas. This is not a new issue and there has not had any effective solution despite many years of discussions. There are some factors that may in fact make this worse.

Although it is not the aim of this submission, I will note briefly that there are two major factors that mediate the decision for a specialist to move to country areas. Firstly by the time a specialist has finished training which can take many years, they are often married with children. They have established links with the community in which their children are being brought. They up often have family in that area, particularly support of their parents and parents-in-law. It is difficult to move away from such regions.

In addition there is a major concern about professional isolation. This has two major components. The smaller the area the more difficult it is to maintain further education and continuing professional development. While there are processes that enable significant components of professional development to be done online, this is not as effective as being able to attend large groups and discuss the latest issues face-to-face. In addition, one of the concerns about professional isolation in smaller cities, towns and country areas is the significant burden of the expectation of taking on large numbers of patients of all types. It is difficult to decline such demands, even though it is necessary to do so. Here I find that after being away, even for a long weekend, we are bombarded with crises, requests for a range of issues, emergency appointments, admissions to hospital, a wide range of paperwork and requests for reports. I have become almost phobic of going away due to the knowledge of the workload that will be there when I return.

However, it is important that patients with serious psychiatric conditions have access to effective treating services. Of necessity this still requires a consultant psychiatrist. Such consultant psychiatrists need to have the knowledge, the experience and the aptitude for dealing with emergency services personnel. Such training is not an area which is well provided for in normal specialist training in psychiatry. Such training is mostly focused on the major inpatient hospital units and on the acutely severely psychotic conditions. As such, they often do not in training get to develop any extensive experience in treating the conditions which affect the majority of patients with psychiatric conditions.

Again access to Internet services and hotline services provide some help, but these have a number of limitations. It is very difficult to establish appropriate effective therapeutic rapport and relationship with the patient without seeing them face-to-face and without a good understanding of their occupational background and the nature of the events that have generated their trauma.

Therefore, the lack of adequate specialist psychiatric services in the smaller cities, towns and rural areas is a major issue. This is further compounded by a number of administrative and bureaucratic burdens placed on the clinician by a range of departments. There has been an attitude across most departments of putting the priority on getting their paperwork done without regard for the additional workload on the clinician nor for the additional stress on the patient. An example of this is Comcare refusing to accept a medical certificate which is not on their format, even though such Comcare are often less pertinent, repetitive, and take longer to fill out. It is interesting to note that the different agencies have their own different certificates and have different ideas of what information is truly important.

One of the issues that needs to be addressed therefore is the desperate shortage of medical specialists in the smaller cities including Canberra, which gets worse as one goes out into smaller country cities and country regions. This issue has been discussed for decades and essentially is unresolved and little changed.

The organisations that run emergency services and the workers compensation administrators and insurers pay little regard to this desperate shortage. Their administrative actions seem to have no regard for this, and at times seem designed to aggravate this shortage and not improve it.

We are still desperately short of a range of healthcare providers and in terms of the college desperately short as specialist psychiatrists with adequate experience and knowledge in this area. This becomes very limited even in the larger rural cities such as Canberra. This becomes exponentially worse in the smaller cities and towns, and becomes non-existent in much of the rural Australia.

In terms of the responsibilities of the various government departments and their agencies, I note that there are problems somewhat similar to the Department of Veterans' Affairs. Many of these agencies and departments have an insistence on convoluted, repetitive, unnecessary and irrelevant paperwork. This causes many patients to feel overwhelmed and therefore avoid seeking help. It causes many medical practitioners and other health practitioners to feel overwhelmed and avoid treating such patients. I note the insistence of Comcare on using

their new forms and certificates which take longer to complete and in fact may have less information than other forms and certificates. We are desperately short of medical specialists, particularly in psychiatry in rural and smaller towns and cities and to waste time on unnecessary repetitive inflexible paperwork compounds the lack that the lack of available time to treat patients.

Communication with clinicians:

Another issue with the emergency services departments and organisations and their workers compensation organisations, has been a lack of any communication at a systemic level between the different emergency services and affiliated organisations in this local region and the local healthcare providers. The only communication has been on an individual level about individual cases. In many of these cases, this communication has been very limited. Much of the written correspondence is cut-and-paste using rote aphorisms which only serve to aggravate the patients and increase distrust their distrust of the organisation.

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