COMMONWEALTH OF AUSTRALIA

Proof Committee Hansard

SENATE

EDUCATION AND EMPLOYMENT REFERENCES COMMITTEE

Mental health conditions experienced by first responders, emergency service workers and volunteers

(Public)

THURSDAY, 30 AUGUST 2018

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SENATE

EDUCATION AND EMPLOYMENT REFERENCES COMMITTEE

Thursday, 30 August 2018

Members in attendance: Senators Marshall, O'Neill, Urquhart.

Terms of Reference for the Inquiry:

To inquire into and report on:

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, with particular reference to:

a. the nature and underlying causes of mental health conditions experienced by first responders, emergency service workers and volunteers;

b. research identifying linkages between first responder and emergency service occupations, and the incidence of mental health conditions;

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, including:

i. reporting of mental health conditions,

ii. specialised occupational mental health support and treatment services,

iii. workers' compensation,

iv. workplace culture and management practices,

v. occupational function and return-to-work arrangements,

vi. collaboration between first responder and emergency services organisations,

vii. post-retirement mental health support services, and

viii. resource allocation; and

d. any other related matters.

WITNESSES

BREWER, Mr Douglas, Psychologist Clinical Coordinator, Trauma Recovery Programs, The Hollywood Clinic, Hollywood Private Hospital

SAMUEL, Dr Mathew, Consultant Psychiatrist, The Hollywood Clinic, Hollywood Private Hospital

Committee met at 12:58

CHAIR (Senator Marshall): I declare open this hearing of the Senate Education and Employment References Committee's inquiry into the high rates of mental health conditions experienced by first responders, emergency service workers and volunteers, and I welcome you all here today. This is a public hearing, and a *Hansard* transcript of the proceedings is being made. The hearing is also being broadcast via the Australian Parliament House website. Before the committee starts taking evidence, I remind all witnesses that in giving evidence to the committee they are protected by parliamentary privilege. It is unlawful for anyone to threaten or disadvantage a witness on account of evidence given to a committee and such action may be treated by the Senate as a contempt. It is also a contempt to give false or misleading evidence to a committee.

The committee generally prefers evidence be given in public, but, under the Senate's resolutions, witnesses have the right to request to be heard in private session. If a witness objects to answering a question, the witness should state the ground upon which the objection is taken and the committee will determine whether it will insist on an answer having regard to the ground on which it is claimed. If the committee determines to insist on an answer, a witness may request that the answer be given in camera. Such a request for in camera evidence may, of course, also be made at any other time. I ask witnesses to remain behind for a few minutes at the conclusion of their evidence in case the secretariat needs to clarify any terms or references used.

I now welcome Dr Mathew Samuel and Mr Douglas Brewer to the table. I understand that information on parliamentary privilege and the protection of witnesses and evidence has been provided to you. Do you have any additional information about the capacity in which you appear?

Dr Samuel: I'm also the clinical lead for the trauma recovery program we run at The Hollywood Clinic, and I work as a private psychiatrist.

Mr Brewer: I also run a private practice specifically targeting trauma recovery.

CHAIR: We invite you to make some opening remarks to the committee, and that will be followed by some questions.

Dr Samuel: At the outset I sincerely thank the committee for inviting us to make some statements. It's an important opportunity for us to be here and be the voice of the people whom we deal with. Those voices are sometimes not heard very well for various reasons. Douglas Brewer and I run a program at The Hollywood Clinic. We've been running that program for a long time. We started with the military and returned Vietnam veterans for a long time. Over the last few years we have been getting uniformed officers like the first responders—especially from the WA police, the Department of Fire and Emergency Services and lately St John Ambulance, which is the only provider of ambulance services in WA.

The issue we have been dealing with is primarily PTSD. It may not be just one episode of trauma but the cumulative PTSD that we have been dealing with. Some of the officers we have had the opportunity to treat have been in the uniform for more than 20 to 30 years, so they've had a long history of PTSD. Sometimes they are under-recognised. That's an issue we are dealing with. A lot of primary care providers such as general practitioners wouldn't have a clue that that particular person may be having PTSD, because they might be coming in with anxiety, depression, alcohol issues, marital issues, anger issues, problems in relationships and disciplinary actions being faced in the workplace—bullying, harassment and things like that.

It is only when they come to us by chance or by hearsay that we have the opportunity to talk to those uniformed officers and then we find that they have a bigger problem, which primarily could be PTSD. If you look at the evidence of PTSD and comorbid diagnosis, you find that more than 80 per cent of people with PTSD will have depression, alcohol use and anxiety disorders as well. While they may be getting help for some of those issues, what may be missing will be PTSD. Our journey for the last few years at Hollywood has been to educate primary care providers by saying that we need to look at PTSD as a diagnosis and that there is adequate treatment for that, and to provide information to employers, employer assistance services, GPs and insurance agencies, because some of these people end up in workers compensation and may not get a very positive attitude from insurance agencies.

We've been on a quest and we are glad we could come before the Senate committee to explore more and try to help these unfortunate people who are very important for our day-to-day life. Although we may not want to see

them on a daily basis, the police, ambulance and fire services are the pillars of health and welfare for our community. I think as taxpayers we have a duty to make sure that their health and welfare is looked after.

CHAIR: Mr Brewer?

Mr Brewer: Working with first responders commenced in 1995, as many of the Vietnam veterans who had returned and been discharged went into other uniformed services to hang onto some of that camaraderie they experienced in the years of their service in Vietnam.

In WA, we were the only centre—the Hollywood hospital—running a trauma program such as these that have been developed by The University of Melbourne. They had a mandate by DVA to put up a centre that was trained and delivering this service in each of the major capital cities and in some of the other cities in the eastern states where there was a large group of veterans. So there were 12 groups running that, and our experience grew fairly rapidly. Because of conscription, many of the veterans had by then, in fact, 30 years or more working as police officers, or paramedics or in other uniformed services.

In 2006 we identified the need to change the nature of the program so that it was more specifically built to incorporate uniformed services. Then further, in 2013 we recognised that with the frequency with which PTSD was now being recognised we needed to run a program that was solely designed for currently-serving people in the uniformed services—the first responders.

That is the program we run today, and still—up until recently—we have been the only providers of such an intensive program. The program being run at the moment is a four-week program. It consists of 15 six-hour days of treatment. That has been really important in giving people a head start in their recovery program and also in getting them back to work as soon as possible. We chose four weeks so that, where possible, people could pull out of the workplace, do the treatment and go back.

I want to talk, just for one moment, if I may, about the changes in PTSD that we've been privileged to see over those years. If we go back to 1995, the concept of PTSD relative to treatment was still relatively new. A lot of research was still being done. The concept was management of the symptoms and that this was a lifelong problem that you would have. Of course, that's very understandable, given that when we were getting people for treatment they had undergone 30 years of trying to manage their PTSD on their own.

It was in the mid- to late 2000s—2010—that we made a major shift. We realised that with younger veterans coming through and also with other personnel in the emergency services that we needed to look at recovery—that we should be looking, as in physical injury, for the maximum recovery that could be obtained from the treatment, rather than just seeing it as a lifelong problem. The emphasis on recovery was to get people back to work or, where that wasn't possible, back to being a contributing member of society.

That changed again in about 2015, as the research gathered and we started to see that we should be looking not just for recovery but that we should be looking for growth—the old adage, 'What doesn't kill you should make you stronger.' So we should be looking for how people actually walk away from recovery from PTSD with more insight and a better understanding of not just their own journey in life but those of others around them. And so that's where we are today: we see the importance not just of recovery but of recovery and growth.

The emphasis of our treatment has been to follow people who are referred to us back to their recovery. To put that into practical terms it's getting them back to a return to work. We, both Dr Samuel and I, take an active role in meeting with the return-to-work provider and the organisation to help steer the tasks that they will go back into and to ensure the return-to-work cycle is being set at a time that's appropriate and with tasks that are appropriate. There are lots of problems in that area, which we'll talk about with you this afternoon.

CHAIR: Do your treatment actually involve family members as well?

Mr Brewer: Yes, it does. Evidence is very strong that where we can involve family members recovery is greater and outcomes are much higher. Currently, with our first responders program, we invite families, friends and significant others to an information evening which we run without the patients being there so the family members are free to talk and ask questions. We don't identify who their loved one is that's getting treatment, so they are free. We're happy, then, to follow that through with the partners and significant others, as they feel is appropriate. That will often involve joint sessions.

Senator URQUHART: Thank you both for coming along. You mentioned, Dr Samuel, in your opening statement hearsay and advice on referral. So I'm interested in what the processes of referral are that have people come to see you. Do you get referrals from GPs, are they from insurers or do people simply seek you out? Can that referral process be improved? If you think it can, how can that be improved?

Dr Samuel: That's a very relevant question. I think that has been our issue, as well, in terms of access. On the kind of patients we get, there's a saying that, 'One patient usually brings five other people.' I think that's what has been going on with us, because one person gets well and they go and speak to five other people. So we recognised that we had a problem a few years ago—that the word was not getting out. We still have a Medicare system, so we rely on the primary care providers to feed through to the specialist and we didn't want to weaken that. So we worked with the College of General Practitioners and we started inviting people. Over the last four years, we got a group of about 40 to 50 GPs into Hollywood and we have been giving them education about PTSD, alcohol dependence and major depression and updates about medications. It is simply impossible for a specialist to see all patients. No 1 it's a financial issue. No. 2 there is a bottleneck for how many people can get into specialists as well. We wanted to make sure that the GPs are well aware of PTSD and that, if a uniformed officer comes along, an important thing is to give them a screening questionnaire. We call this the PCL and it's very simple. It takes only five minutes and has 17 items. They do it very quickly in front of the GP, and the GP can find out whether they have PTSD. That is No. 1. No. 2, if they come with alcohol, they should always ask about PTSD as well. Then we talk to them about medications, we talk to them about the different kinds of therapies. We also have given them information about the psychologists they can refer these patients to. That has been our primary aim for the last four years.

The other thing is that over the last few years there have been a lot of services and support agencies. I think Sirens of Silence are coming here after us. So there are people like that who are supporting the first responders in the community. We have done a meet and greet. We have brought all those people along once a year, and then we tell them: 'While in your journey if you find somebody with a problem you don't need to ask anyone else. Just give us a ring and we are more than happy to see them.'

Then the other thing we have done is go and speak to all the health and welfare people of all the various departments, such as the WA police. We have a very strong relationship with WA police Health and Welfare, especially with the psychologists, the OTs, and people who are running the Health and Welfare. We have met with the Department of Fire and Emergency Services, and Doug and myself have been involved with this, and St John Ambulance—Doug is actually on the advisory panel for St John Ambulance. And then we have talked to the patients as well. One important thing we do is that we bring in people—so when we are running a group program, we bring in somebody who has already done the program to tell the people that, 'Look I've done the journey, and this is how I have been.' And that is a very powerful statement for the people who are there, by saying that, 'Well, there is a light at the end of the tunnel—I can move forward.'

The bottlenecks, the problems we have, it's still the reluctance and stigma associated with mental illness. Number two, all these agencies are single providers. We don't have two ambulance services; we don't have two police associations. If you are not in one job, you know, then the question is: 'What will I do? This is what I've done for 30 years. I don't have any other things to do if I have to go somewhere, move interstate or move across the country to another place.' So reluctance for people to come forward is a big issue. Then the problem with the officer in charge, who is the superior officer: 'What kind of attitude I'll get if I say that I've got a problem—what kind of response I'm actually going to get.' I had a police officer yesterday—a WA police officer can get, I think, about 165 sick days. She has taken only three weeks but she's already under a human resource watch, saying that: 'You have taken three weeks off sick leave.' So when I told her, 'You need to take one more week', she was horrified, because she was not sure about the response from the OIC and what would happen. So there is that stigma associated with a mental illness.

Senator URQUHART: That sort of rolls into my next couple of questions. What would need to change to encourage first responders to disclose their PTSD to their employers? Do you have any suggestions for how that stigma around PTSD and mental health for first responders could be reduced by their employers?

Dr Samuel: Yes. I'll let Doug answer some of this as well. But I think the important thing, again, is to change the culture. And that has to come from the top. I would say for the WA police, it has to be from the police commissioner putting out a statement—because there is a fear among the employers that if we talk about PTSD there is going to be a plethora of people who are going to come and say: 'Look, I've got PTSD, I need compensation.' But we forget the fact that police officers, ambulance officers, and fire service people come to the job because they have got that high, altruistic attitude towards the community. They want to do something for the community.

CHAIR: How recent is that example about the sick leave? We're going to hear from the police force later today.

Dr Samuel: That was yesterday.

CHAIR: Yesterday. I can bet you now that they're going to tell us they are 100 per cent on board with this program, full support, and no-one would ever be questioned like that; that would be outrageous.

Mr Brewer: I think that goes back to the question you were asking. It certainly needs to start at the top, as Dr Samuel was saying, but it also needs to filter down—if we take the police force, for instance: whilst you'll get that response from those in authority, certainly from Health and Welfare, the person that these people are responding to is their officer in charge of the centre, and they are often people who are wounded themselves. They have their own mental illness, but are totally denying it. And in order to deny that, they're very harsh on those coming through: 'You've just got to toughen up. Who do you think you, needing another week off?' But these crusty characters, as they often are, are often the problem in people wanting to open up. They'll open up, and some will go to their respective Health and Welfare, or whatever it's named, but have still got to deal through their management. There has been some discussion with WAPOL. We've had some meetings about how we might sort of work towards that. Could we run a program for sergeants, or officers in charge—which is probably a little bit more important, I think—on mental health and what to look for? So there's that middle ground that certainly needs education and changing.

Senator URQUHART: That's certainly been what we've been hearing through this inquiry—that that top level is quite often on board, but then it doesn't seem to filter down and the changes don't actually occur. The people that are suffering from PTSD or trauma are actually then responsible to talk to those people who are basically not accepting of what is happening.

Dr Samuel: The other issue we have is that the police have got a police psychiatrist and the St John Ambulance have got a psychologist, but how many people who are going to go openly and tell the police psychiatrist, 'Hello, I've got PTSD and I need to be stood down'? They will be horrified. So we have got this issue. So they come to see me as a private psychiatrist, and then they go and see a police psychiatrist and tell an entirely different story. Then the police psychiatrist says: 'So who is telling the truth here? Am I telling the truth?' I said, 'Well, this is the issue we have.' Again, I see a lot of SAS soldiers, and it's the same issue. What SAS soldier is going to go out and say, 'I've got PTSD'? The first thing they will say is that you are stood down. You're not going to go back—

Senator URQUHART: They fear for their job.

Dr Samuel: Absolutely. Then they have a problem later on by saying that it's an issue. So I think to streamline it, the No. 1 thing is education from the top. We have done extremely well. Agencies like beyondblue and Black Dog Institute have done extremely well in educating the normal population regarding mental health. But where we have failed unfortunately in WA is for the uniformed officers, the ambulance, the fire service and the police. We have failed in infiltrating that message across to the people. For example, I managed to get one of the officers who's now medically retired to tell the story in the police union magazine. With that story I got 10 other phone calls saying, 'Look, I'm glad that you told that story and you were able to tell that because I never knew that I had a problem, but now I know that I have a problem.'

Senator URQUHART: I don't think that's unique to WA. We've seen it on the eastern seaboard.

Dr Samuel: We can see that in Australia we have done very well in terms of penetrating the mental health literacy across the normal population. Why can't we do that to the uniformed officers who are very important? That's the question I would really love to ask all the top people by saying this is the issue we have.

The other thing is streamlining the referrals system. They should have a place where they can go without fear, without intimidation and without any bureaucracy to speak to someone and say: 'Hello, I've got a problem. Is this a problem? Should I be doing anything about it?' without the fear that that would go straight to the employer.

Senator URQUHART: The confidentiality aspect.

Dr Samuel: Absolutely

Senator URQUHART: I'm interested in your four-week treatment program. Can you just take us quickly through the outcomes of that. Are there any good general success stories that you can actually share around the results of that?

Mr Brewer: Yes, thank you, Senator. As with any treatment program, outcomes vary. I think one of the things I noted earlier on was that we often tend to get cases that have been really difficult to manage from various organisations, and then as a last resort they'll find us and send them along. So we have to filter in that we've got some that are difficult. But I think the success that we really look for is when we get a successful return to work. There are two areas, I think. One was a police officer who, as many do, feared to acknowledge, because of his seniority, that he had PTSD. He took four weeks annual leave and paid for the program through his own private health funds. He returned to work following the four week program. In our reviews of him later on, no-one ever

knew that he had come in for treatment. I think that was a great example of what occurs. Generally speaking, most of the return to work will take somewhere between four to six weeks following the program.

I should mention that in treatment of PTSD generally, most psychologists see the importance of doing exposure therapy. That will be prolonged exposure or EMDR. We do very little exposure work, because of the variation within the group. We can do that with military, but not with these groups. If exposure therapy beyond what we run is needed, that will be done one-on-one. Either we will do that ourselves or, if they have a therapist that they were seeing before, we will send quite a detailed letter on what is needed. That is done. Given that that may go on following the program, usually there's a four- to six-week return-to-work program. We try to have a fortnightly meeting to see how that's progressing and what next level of work should be needed. We did strike some problems with that. In the earlier days with St John there tended to be a one-size-fits-all approach in return to work if you had PTSD.

Exposure is not always the problem. I want to make that clear, because that's one of the problems we see. Very often we have a moral wounding. The person's values, beliefs and rules for living have been challenged to the point that they no longer have a reference to go on and make sense of their life. That's a very strong part of the program. Another key part of the program is allowing the individuals to verbalise their disgruntled approach to their organisation without shutting that down too soon, but carefully shifting that focus to say: 'This is true in any organisation. How do you become the agent of your own change? How can you go back into that organisation, work within that system and keep yourself safe?' That focus within the program has enabled us to get many back to work that hadn't been able to go back. As with all treatment of PTSD there are those whom, in working with them, we encourage to see that they are no longer able to go back to the area of work they've been in. For their own health and future quality of life they need to be steered into another area. Again that's something which we work on that often takes many months. Medical retirement through WAPOL may be a six month program, and we'll often see them on a fortnightly or monthly basis through that journey.

Senator URQUHART: Are they usually re-employed through WAPOL or in a different—

Mr Brewer: No, once the medical discharge has occurred, with all of the organisations, there is no further work. That's one of the key problems—that identity is linked to their career in uniform.

Senator URQUHART: A lot of the submissions and witnesses have argued for presumptive PTSD within the workers compensation setting. As clinicians do you see this as a useful step? Is there enough evidence of a causal link between the cumulative trauma of emergency service work and mental health injury for such a step to be considered by insurance?

Dr Samuel: I think I can answer part of it. There are mental health issues which are beyond PTSD as well. I don't think we can say that all the work related issues are PTSD. We are governed by a classificatory system, so we need to follow the DSM-5 or the ICD-10. Unfortunately they have very strict guidelines and criteria. You need to have criterion A and criterion B. They have very strict definitions regarding PTSD. Cumulative PTSD has been acknowledged by the DSM-5. I think that can be a bit frustrating for people. Some people think they have PTSD and, when they come to see me, and they say that, I have to say that they may not in fact have PTSD, but that they do have major or persistent depression, an anxiety disorder or an alcohol-use disorder. We cannot have a presumption of PTSD for all workers comp. That's not the way to go. They all need assessment not by insurance agencies or the employer's psychiatrist but by an independent psychiatrist who can verify that and is trained to do that. Not everyone will believe in or want to diagnose PTSD. So we need to create a panel of people who can help these individuals. That is why at Hollywood we do both objective and subjective assessments. We do an assessment called CAPS, which is a gold standard for assessment of PTSD, and that is a clinician graded scale, and also the PCL, which is a subjective rated scale.

CHAIR: You mentioned that before. I'm interested in this. What is the veracity of that sort of a test? I've got concerns that, if you've got an insurer who is motivated not to pay claims, you put people through an adversarial process, which probably worsens the injury. If we weren't going to do presumption up-front, if there is that test that is accepted—like you said, it only takes five minutes to do and you tick the boxes and it'll tell you whether you do or you don't have PTSD—is that enough? If we get to the point that people can do that test and therefore, whatever that test says, the claim is accepted, it's a presumption at a sort of different level.

Dr Samuel: I think it has to be taken in the context as well. It is just not that somebody who is doing a PCL can be diagnosed with PTSD. PCL is an aid; it's a screening tool. The CAPS—

CHAIR: Will that differentiate the issue that you raised before? Someone is unwell, so they're seeking the help, but it may not be PTSD; it may be depression or it may be some other mental health issue. So the issue isn't whether they're unwell; the issue is you're screening out other problems or you're screening out PTSD. I'm

probably not being very clear, but I'm trying to find a way where you can actually spare people going through company-sponsored adversarial processes by saying, 'Well, this is a simple test. If you get through that process then we do accept the claim.'

Mr Brewer: You really identified a key problem here, I think. Even if we have something that says, 'You've passed this,' if you get past the cut-off point that we have in those sorts of scales, with someone who comes one point less than that, do we dismiss them and say, 'Well, you're healthy; you don't need that'? That's the problem we get further down the track when, as you identify, we get insurance companies who want to farm them out to have a second opinion and then there'll be the debate about, 'Does this meet the criterion or not?' One of those is commonly bullying. We know bullying is a large contributor to PTSD. But if it's the bullying that's been identified, and all those other traumas that haven't been that are there in the frontal thinking of this individual at the moment are missed, then we dismiss the issue and say, 'This is not a claim.'

CHAIR: I'm also worried about the damage it causes, because you have a situation where a psychologist or a psychiatrist, not in an effort to assist the person's health, is questioning and making people relive the process in an adversarial sense, where it's not part of a treatment; it's actually part of an exposure program, which has to make things so much worse, and we do it time and time again. You get one, another one and another one. I think what we're trying to look for is a process where claims can be assessed and dealt with and accepted or rejected quickly so that people can actually get help. But how do we get that? If we don't simply say there's a presumption, how do we make that easier and avoid the adversarial assessment?

Mr Brewer: I don't think we do, and I think that there does need to be a presumptive sense. The question I think was asked—there is enough evidence now, internationally, not just nationally, that first responders' repeated exposure to trauma does have a cumulative effect. It does weaken the individual. It may be cumulative and weaken them to the point that they don't get PTSD but they have very deep depression or else they have burnout. In that sense, that's why I'm just a little bit hesitant in jumping into presumptive legislation, but I think it certainly needs to be there, because it would make a big shift—presuming we've got an individual who in the workplace has been damaged. Let's take this, because the delay in getting treatment is often—

CHAIR: Are we focusing too much just on PTSD? Should we be saying that there's a test and a presumption for a mental injury? If it's not PTSD in the end, well, so what? People are unwell and need to be assisted.

Senator O'NEILL: Yes—like your leg or your arm; it doesn't matter. You've got to get a treatment for whatever the—

Dr Samuel: Absolutely. I think we see a range of mental health conditions anyway. We don't know—can we call it—

CHAIR: But the screening test that you were talking about earlier—will that do the go and no-go? If an assessment is done on that, rather than having to go through the adversarial psychiatric evaluation from insurance companies, if that test you were talking about said, 'Sure, there's a mental injury'—we may not be specific about what it is—once that test says you have one, then the presumption is it's work related.

Dr Samuel: Okay. I should probably take a step back then by saying that the PCL is only for PTSD. It is actually not for other mental health conditions. So it doesn't screen things like depression. It does not screen things like alcohol disorder. It does not screen things like anxiety disorder or persistent mood disorder. I think the reason why I talked about PCL is that our GPs are very good in assessing or diagnosing major depression, anxiety, alcohol or other issues, but what is lacking is the diagnosis of PTSD. So we have talked about the scale or given an indication of what the scale is to make sure it is clear that there is one level which we are missing. We are missing the fire which is burning underneath, which could be the cumulative PTSD.

There are other tests. For example, there is the primary health questionnaire No. 9 that has been developed by the WHO. If you use that then that gives an indication of whether they have a mental illness or not. GPs used that quite commonly. If you go and say that you're depressed or you're sad, most of the GPs do tend to use a different screening test anyway. But the PCL will do one level higher, which is to identify the PTSD. So, again, as Doug said, the cut-off is 50. If somebody gets 49, does that mean that they don't have PTSD? No. It is basically to alert the fact that you could have some of the symptoms. When I look at that, I say, 'Okay, so you're having problems with sleep. What kinds of issues are you having with sleep?' And then we talk more about that. It also becomes like a flag for us to inquire more. But that particular scale will give us a bit of an idea. We probably talk more about PTSD because that is what we deal with on a daily basis more from the uniformed officers in terms of mental health. But, from a mental health point of view with first responders, PTSD is only one part of it. There is burnout—we don't even know what we call that diagnosis. It is not depression, it is not anxiety and it is actually not PTSD, but then what is it? Chronic burnout is actually a common problem that we face.

We should not forget the physical issues associated with PTSD. I think there was a paper published in *The Medical Journal of Australia* at the beginning of the year which talked about the high incidence of heart attack, the high incidence of diabetes, the high incidence of stroke, and the high incidence of high blood pressure, high cholesterol and weight gain, and the issues with knee and joint pains and things like that. If a uniformed officer goes to the GP and says they have developed diabetes at the age of 50, how many GPs will ask about PTSD or depression or anxiety? 'Is this one of the reasons why you have developed diabetes?' We are trying to change that by saying: 'Can we talk about it? Is it okay to talk about it?' It's important to talk about that as well.

Senator URQUHART: One of the things you talk about in your submission is the lack of treatment options in public hospital systems. One of the problems that we've heard a number of times is the lack of mental health specialists who understand the unique challenges that first responders face. People are sent off to get some assistance through an employee provider, an EAP process, and they get a person who doesn't have the expertise. Is there a similar problem here? How do we overcome that issue?

Dr Samuel: I think the main problem for first responders is—when I speak to a police officer, for example—they'll say, 'I don't want to go see somebody in Fremantle Hospital or Sir Charles Gairdner Hospital or Royal Perth Hospital.' Why? It is because that's where they go as part of their work every day. Who wants to be identified as a person who says 'I have PTSD' or 'I have depression'? The moment you say 'PTSD' to the triage officer at Sir Charles Gairdner Hospital, I can bet—100 per cent—that they will say: 'You're not acute. You can actually go home. We'll call you in four weeks time.' Unless you are suicidal, you don't get any treatment in public health services anymore.

Senator URQUHART: What about employee assistance providers? That's one of the issues that we've heard about—the lack of understanding about mental health issues. When people are sent off to an employee assistance program, the people they see are obviously there to try and help them but they simply don't understand the issues.

Mr Brewer: Unfortunately, I think it's inherent in EAP providers because the concept is to provide counselling services to employees for up to six sessions. It tends to attract psychologists who are just starting their journey as psychologists or, because there are only six sessions, people who are wanting to come back but don't want added responsibilities. PTSD and understanding the uniqueness of each of the services, not just first responders generally, are things that take a long time to understand. That is a constant problem. We regularly hear of people saying, 'I started to open up and the counsellor, the psychologist, left the room in tears.' I find it hard to believe that my own colleagues can get to that stage, but it is true.

The other problem is the lack of education out there. We clinical psychologist like to think that we're skilled in every area, but obviously when you specialise in an area you get those additional skills. The downfall I see is that we often move to something that's quick and fast like EMDR, which whilst is now evidence based is still not the answer to all PTSD and doesn't deal with the often accumulated process of trauma after trauma—the changes that have taken place in the person's personality. How do you crawl into bed at night and become a husband or wife after just dealing with a tragedy? The changes that occur are part of the recovery process, not just dealing with a trauma.

Senator URQUHART: I come from Tasmania, and we have no specialised services. People have to go to Victoria to get specialised services. We currently have a number of our paramedics in Victoria being treated for weeks on end. They're separated from their families, their loved ones and the people who can actually support them, simply to get treatment. It seems like it's an issue pretty much across the country. Do you have any comments on how to improve the reporting of mental health conditions within emergency service organisations so that we can base policy on evidence while at the same time respect client confidentiality?

Mr Brewer: It's improved—and I can certainly see that—but I don't know that I would like to bank decisions on the data that we get. There's still way too much nondisclosure and there are still an enormous number of people who have severe mental health but are still in denial. When we were working with the military in those early years, one of the things that we looked at to define whether there was PTSD or not was denial. Once you recognise that's happening in their responses, you tick the box in your head and say, 'Let's go further; we've got someone here.' That still exists to this day, so I don't think we have that data.

CHAIR: But there is just so much data around now that's being collected. Do you see maybe a time not too far away where you may have it? I must say that I'm staggered by the amount of data that the public health system is now collecting—including triaging people in emergency departments where they can have predictive models on how long people are likely to spend in an emergency department or how likely they are to be admitted. The data is so enormous. Following on from my earlier question, if there were some model or test you could apply or data analysis of the symptoms with which you could then do the presumption, or a precursor to the presumption, it would certainly go a long way.

Mr Brewer: I absolutely agree with you. I often say there's no room for ignorance when it comes to PTSD now. There has been enormous funding and research worldwide in this area, so we have absolutely incredible data that we can work on and move on. In responding to you, I was really wanting to say that, although we have the data, at present there's still a lot unrecorded and we need to estimate that. There are good estimates out there such that even the data we have, I think, is sufficient to make a move on. The cost of not responding to effective mental health treatment of first responders, I think, is huge.

CHAIR: I would like you to develop a model for us before we report in a number of weeks, if you don't mind. That's in December. Just email it through to the committee. We'll appreciate it.

Dr Samuel: One final thing I will say is that what is lacking in WA is that we are far from anywhere for our people to go and get treatment. Adelaide has got an institute of mental health in PTSD, Victoria has got Phoenix Australia and New South Wales has got the Black Dog Institute and other things. What is lacking in WA is a centre of excellence. I've been speaking to our honourable MLA, Mark McGowan, and he has got a mission. We've been talking about establishing a centre of excellence. That centre of excellence can be a place where people can come and get treatment without any fear or prejudice and where people can probably self-refer. They don't even have to go to a GP and say, 'Look, I have a problem.' People can walk in. That could be one model. This is such a big state and we have issues in getting across to the people who are living in the country and rural towns as well.

Senator URQUHART: That's right. It's much bigger than Tasmania.

Dr Samuel: Yes, and I think that will be one model that we will be thinking about here, but it needs funding and political and community support as well.

Senator O'NEILL: The article that you referred to that talked about co-morbidities with PTSD, could you provide that for us on notice?

Dr Samuel: Yes, of course.

Senator O'NEILL: The other members of the committee might be more aware of the 'moral wounding' you talked about, but it's the first I've actually heard of that. I would be really interested if you've got an academic article of note. I would really like to read a little bit more about that and understand it. In another inquiry we were holding this morning, we were talking about workplace risks for first responders, particularly police, with access to arms et cetera. Have you been consulted in any way about recommendations for safe workplaces in response to a level of PTSD that seems to be highly unreported? That makes those workplaces, in my view, seem extremely high risk.

Dr Samuel: Yes.

Senator O'NEILL: What's going on in that space? If you could take that on notice and provide some answers, that would be good, because I think we're out of time.

CHAIR: Yes. Dr Samuel and Mr Brewer, thank you very much for your contribution to our inquiry.

Dr Samuel: Thank you.

FOLKARD, Mr Mark, MLA, Private capacity

[13:50]

CHAIR: Welcome. Is there anything you'd like to add to the capacity in which you appear?

Mr Folkard: I'm the MLA for Burns Beach, but today I appear as a private citizen.

CHAIR: We have received your submission. Thank you for that. We now invite you to make some opening remarks, and that will be followed by some questions.

Mr Folkard: I apologize, firstly, for the rawness of my submission. I believe it in that particular space, but, to be frank, it needed to be that. I hope you've all had some time to read that document. I cannot stress enough that untreated PTSD kills. It may be one of the greatest causes of early death in our first responders. I don't know—I can't find decent research to reflect that—but anecdotally I think it sits in that space. Untreated PTSD will lead to chronic illnesses. This statement comes from credible, peer-reviewed research from the United States. Personally, I've developed type 2 diabetes. I'm certain that my diabetes has come about through my PTSD. The time line of the illness appears to match, on reflection. When I first started to suffer from the infliction was around the time that I picked up the diagnosis. That's my own personal experience.

To demonstrate how serious and how life threatening the illness is: I was campaigning back in December 2016, and whilst I was campaigning I received a phone call from my doctor. He directed me to head straight to A&E. I asked why. He said, 'I've just got your blood tests back, and your sugar levels are in the extreme spectrum.' He said, 'Get to the nearest A&E as quick as possible.' I still wasn't convinced by that. I asked why. He said, 'Because if you don't there's a strong possibility you're going to go into diabetic shock or coma.' I immediately went down there. You know the old pinprick you get on the finger, the sugar test? Well, I took that and the poor little machine spat itself. It said, 'Too high; I can't give you a reading.' The personnel at the A&E panicked a little bit and shot me straight into the back room. They were able to do what they were able to do, and I'm still here. It is a genuine part of PTSD.

I've had friends who've developed cancers who don't have a history of it. I've had a dear friend of mine have a double mastectomy with no history of breast cancer in the family. She's 37, I think, from memory—young. She is a sufferer of PTSD. I've had others with heart illness, hypertension and depression. I've got a dear friend of mine who I deployed to East Timor with. He got a diagnosis of PTSD. Around the same time, he picked up a diagnosis of hypertension and, as a result, he's had a stroke. I can't stress enough: it's the chronic illness that will kill you. It's not just PTSD. I can't stress that enough. It's the depletion of your immune system, which then leaves you vulnerable to these other conditions.

As an ex-WAPOL officer, I've actually received nothing. I have a workplace injury. I've had no financial help. I've had no assistance, with no redress whatsoever. I have to self-fund my own treatment. The two people who gave evidence to you previously are my clinician team. As I said, I have to fund all of it out of my own pocket. Within Western Australia, if you receive a diagnosis of PTSD within the agency, the same person that gives you the diagnosis within the agency is the same person that gives you the recommendation that you've got to leave. As a copper in WA you get four weeks notice, shown the door and that's it. Once you get shown the door, you don't see a cent. Western Australian police are not covered under the workers compensation scheme. We're not seen as employees. We have partial coverage of it, but not full coverage. My treatment and anything in that space is funded out of my own pocket.

One of the other things that I have to deal with within my own space is that if I were to change my health insurance I'm really worried that I would never get reinsured again. I'm lucky that I maintain my police private health insurance, but I'm very much mindful that if I let that lapse I might not get reinsured again in the health environment. The other thing is that I can't get personal insurance, because I've got to disclose to people that I have PTSD and I have to disclose to them that I'm a type 2 diabetic. As a result of that, I'm finding it very difficult to get private insurance in that space. That's a commonality across all of us.

I was thinking about this last night. During my treatment program with Doug, he made a comment, and my wife reminded me of it. When I was in treatment, Doug Brewer said: 'You must be prepared for the bad days, because they're going to come. You've got to be prepared for that. This preparation is coming to terms with the condition.' For me, I've been very lucky. I don't want to be negative; I've used the condition as a strength. You can't sit around and let the infliction control you; you must own it. This is my belief, anyway. To own it is the only way that I can progress in my own personal space moving forward. Having read my submission—I've had a real good think over it. I believe that the way forward is to get recognition that PTSD is a workplace injury. We've got to be in that space. I think I made a comment in there that the World Health Organization made the comparative statement that PTSD has the effective apparent level of paraplegia. Effectively, if you've got PTSD

you may as well be in a wheelchair, because that's the sort of infliction that it is. On reflection, in my circumstance, I tend to agree with that. It can be very buggering at the best of times.

I think presumptive legislation is a must. I was listening to your comments earlier on. There's heaps of research out there. My experience is that, roughly, if you're a first responder, a St John in that space, it's about seven or eight years that it tends to grab you. With policing, it's about 15 years. I did 27 years as a copper, and the time line seems to fit. For a fireman it tends to be about 20 years, and I don't know why. Maybe we need some good people to look at. There will be unique circumstances with that. It may be earlier, and that may fall out of kilter with that. But, as a general guide, I tend to think that's a pretty fair comment. The presumptive legislation—if you've done that sort of service it's out there.

PTSD is like carrying a bucket. For some of us, it's a big bucket. It's huge, it's full of water and it's heavy. For others, it's a small light bucket. Some days that bucket can be big; some days that bucket can be small, but you still carry it. That's it. We need dedicated mental health facilities that specialise in PTSD in all the states. We don't have one here.

I'll give you an example. I found a colleague of mine wrapped up in the corner in the foetal position, crying like a baby—she'd just tried to kill herself. She'd been referred by the department's psychiatrist to a second psychiatrist for treatment. She'd been seeing that psychiatrist for five years, and she misdiagnosed her. It was lucky I found her, and I was able to get her to some people who actually understood the condition. There are a lot of people out there in this industry who are making money from the misery of first responders who are absolute frauds. I can't stress that enough.

As I said, we need a dedicated facility. We need the research to go behind these facilities. Here in the west—I don't know how it goes over in the east—by having universities, and particularly their medical faculties, embedded in the facility we can get the best preventative actions, the best treatments and the best ways to drive cultural change within the agencies. WAPOL—listen, they're not even in the library, let alone on the same page. They just don't get it. You'll have them come in here today and explain that: they'll tick all the boxes—they're magnificent and all that sort of stuff. But after 27 years of looking at it and literally having to intervene with my own peers, colleagues and young constables to make sure that they were all right, I wouldn't even call them amateur. They just don't get it.

I don't want to mention names, but a Western Australian parliamentary committee had the previous police commissioner say that PTSD isn't an affliction within his agency—and that's as recently as five years ago. That's on the public record—I don't have to name and shame but that's there.

Also we need some sort of white card or yellow card system to ensure that the sufferers actually get proper medical treatment. I look at my own personal circumstance. We're covered by RiskCover here in the state of Western Australia, and eventually that money runs out. But these afflictions, and particularly the chronic illnesses, last a lifetime. My biggest fear personally is: once I stop doing what I'm doing now, how am I going to be able to treat myself in the future? There's nothing—there's nothing out there.

I saw in Western Australia that they section 8 you, right. If you commit murder as a copper you get a section 8 notice. If you're sick from a workplace injury, you get a section 8. There's no disparity there. I believe we're looking at that in time, but that's how it currently sits. There's such stigma attached to being a section 8.

Early on in my treatment and in my treatment cycle, I was able to get an understanding that my days as a policeman were coming to an end. I took the journey—here I am: I'm a member of parliament. So for me, personally, I don't have a section 8 notice. I left the agency because I had a workplace injury—I effectively had my arm cut off. I don't have that physical side of walking around with one arm. That's just the way it is.

The other thing is that I listen and I hear, and I took the time to read as many of the submissions that were put in to you as I could, and there's no dedicated funding source for the treatment of this illness, across the board. We're reliant on the health systems out there or the workplace injury compensation stuff, but eventually that's finite. What happens to the people, particularly once they develop chronic illnesses as a part of this infliction? What happens to them after that? There's nothing. With the DVA, the Vietnam vets have their gold card and their white card, and that covers them. I'll give you an example. My father was a Vietnam vet. He developed chronic heart disease and had a heart attack. He went straight up into the local hospital. Because he had a veterans gold card, they went straight to the mountain and cracked him open in two days. If he'd been a normal person or one of our first responders here in WA, he would just have been thrown on the list. The chances are that, if my father had been sent home, he would have been in a grave now. So we need the white cards and that sort of support.

First responders are all of us. The other thing that is probably not covered in here and that I haven't heard today is that first responders are actually a fairly large chunk of our community. You've got the three professions—the

ambulances, the police and the firemen—but you've also got your volunteer ambulance drivers, your volunteer fire brigades and your surf lifesavers. They're first responders. The other one is your volunteer marine rescuers. They're first responders. It has not been addressed. These people are definitely first responders. If a 15-year-old kid drags a body off a beach, you can't tell me they're not going to be traumatised by that. One of the things is that we've got to define what is a first responder, and we need to approach this.

If you have a look in that submission, I did a napkin exercise. I think there are about 60,000 to 70,000 first responders here in this state. I'm not sure about that; the figures are a bit rough. But, just crunching the numbers and using the beyondblue figures, one in four people suffer from mental illness or have some sort of infliction. Using those numbers, there are roughly 15,000 people in Western Australia suffering from some form of PTSD. We know that, for a normal person, normal illnesses cost them about $5,000 a year. If it's chronic conditions, it's about $10,000. Those are just figures I've picked up out of the paper. I'm sure your researchers will be able to find further material. As I said to you, PTSD leads to a chronic illness, so that's $10,000, and $10,000 by 15,000 is 150 million bucks. I can't stress this enough: how are we going to fund the treatment of these people? That's something we've really got to look at. I'm suggesting, from reading all the submissions, that it is an absolute infliction for our first responders. That's a napkin exercise that I did. If I were to sit down and really crunch the numbers and really go hard in that space, I would suggest that number's very much underdeveloped, particularly for the coppers. I reckon that there are 6,500 coppers here now. If we work on a basis of one in four, that's roughly 1,500 coppers suffering from some form of PTSD. I reckon that's very much understated. I reckon it could be as much as a couple of thousand, and that's just in the police force here in WA. If you throw that across the country, the numbers get staggering.

What we look at is so important. I can't stress the link between PTSD and chronic illness enough. If you treat the infliction, the likelihood of you developing these chronic illnesses is reduced significantly. I'll leave it at that.

CHAIR: Thank you. Mr Folkard, you said you've gone through a program yourself. Where does that leave you?

Does that leave you in ongoing treatment, or is there a process where you say, 'I've gone through a program and I'm now free from the injury'?

Mr Folkard: Make no mistake: there is no cure for this hideous condition. We talk of recovery, not cure. I have bad days, and I'll pick up the phone and I'll ring Doug, and I'll say, 'Mate, can I get some time with you?' and they make time, and I'll go down and spend an hour or so with him. And that is ongoing. There's no cure for this. You may have people come in and talk to you about, 'This is in this part of the brain,' and all that sort of nonsense. PTSD is a physical change that occurs in the brain brought on by critical incident stress. There's no cure. We talk of recovery. I don't think you heard the word 'cure' come out of their mouth. It's like maintenance. I have dark days, and they're shit. But, as I say, you come through it. When I need help, I'm lucky—I can pick up the phone and say, 'Yeah, I need time to come and talk.' That to me is so important. And I have a good family around me.

Senator URQUHART: Thanks very much, Mr Folkard, for sharing your personal story with us today. You raise the issue of volunteers. We've had quite a few submissions, and we had evidence in South Australia yesterday, from groups of volunteers that cover a whole range of volunteers, those in marine rescue and a whole range of others. We've also had submissions that relate to the telephone environments—I'm not sure what you call them; the call centres where people phone into that room. It certainly widened my thought basis about what first responders are. We've also had submissions from emergency nurses and people like that who are actually at the front level of that. So it's a very broad definition. I think that, when we first started this hearing, it was around ambulance, fire and police. But from my perspective now, I understand that it's a whole lot broader, and we're not shutting anyone out from that respect, because we have had submissions and evidence, which is good. During your time on the force, were you aware of support services that were available?

Mr Folkard: They used to fire us an email with an attachment. It used to be based on self-diagnosis—dead set! Early on in my career, they used to send this up: 'Listen, we'll send you a voucher; go and buy a box of beer and drink it off with your mates.' That was their approach to it.

Senator URQUHART: So no real support services, as such?

Mr Folkard: No. They're a little bit better now.

Senator URQUHART: I'm talking about simply when you were in the force—you weren't made aware that there were support services that were available?

Mr Folkard: Every time we had a critical incident—and not even every time.

Senator URQUHART: Just step me through the process of what it was like when there was a critical incident, as to what sort of support you received.

Mr Folkard: I mentioned in my submission: I held a young constable's chest together after he'd just been stabbed. We went through that step; we went through to the other side. I'm holding the young guy's chest together and I'm running the job while waiting for the ambulance guys to get there. Yes. Great. Happy days. I'm running the job. We've had an officer stabbed in front of us. I've done what I've had to do—first aid and all that sort of stuff. At the completion of the exercise, I got a phone call from a senior officer to say, 'Thank Christ you were out there.' That was the extent—nothing.

I'd been to another situation, a plasma explosion, where there was a triple fatality or a double fatality—I can't remember; it was a triple fatality, I think, from memory—and I got an email. I actually printed it off and put it into a plastic thing, because it was reflective that you had to admit that you had a problem. It didn't actually mention anything like: 'Listen, you're having a problem if you're losing sleep; you're having a problem if you've unexplained anger; you're having a problem if you're losing the ability to concentrate.' It had nothing like that. It was just: 'If you're having a problem, this is the phone number.'

Senator URQUHART: So you had to sort of identify yourself what the issues were?

Mr Folkard: Yes, by yourself. There wasn't anything along those lines. I debriefed after that job the coppers who I was directly responsible for, but there was nothing—no professional services; nothing. The agency had done a whole heap of work in mental health first aid, but really they don't even touch that. They'll go tick, tick, tick. It's all reliant on self-diagnosis.

My journey into this space started when I was having problems with anger and concentrating. What used to take me 20 minutes was taking me eight hours, so I was really battling in that space. I went to my GP. I did not go to any of the agency's psychiatrists or anything along those lines—

Senator URQUHART: Was that offered to you?

Mr Folkard: No.

Senator URQUHART: But you knew they existed obviously.

Mr Folkard: I knew that they existed but, because they're the people who make the decision as to whether you stay or go, I said, 'No, there's no way.' So I went to my GP. My GP gave me a referral to Matt. I then did some homework to make sure that he was a person with some credibility in that space. The research that came back was pretty positive. I went and saw Matt. It took me three months to get in to see him. From there I started my treatments.

Senator URQUHART: So what services, if any, do you think would have improved your experiences when you were in the force?

Mr Folkard: Cultural change. The services themselves—

Senator URQUHART: What's the first step to that cultural change? I think I mentioned this earlier. We have heard about the people right at the top—the commissioners et cetera—all saying, 'We have services and we want people to be able to be comfortable—

Mr Folkard: It's got to be more than lip-service. Does that make sense?

Senator URQUHART: Yes. How do we do that? How do we have that cultural change?

Mr Folkard: We make consequences for those senior officers who fail to intervene and make sure that their people get the right treatments. It is a reflection on them and becomes a performance indicator for their contracts. If they don't live up to the game, they get fired. I need to be as ruthless and as blunt as that.

Senator URQUHART: I know about cultural change and how difficult it can be sometimes to get that cultural change within a middle level of management. If the people who are experiencing issues, such as you were, don't feel comfortable talking to the people at the next level, who do they go to while that cultural change is actually happening?

Mr Folkard: That's a good question.

Senator URQUHART: You may not have the answer.

Mr Folkard: The pastoral care of the officers is key. Over the years we've had some very good police padres. Maybe we should be increasing that process and maybe that is part of peer support groups and peer support schemes. It needs to be deadset embedded into the agency that a peer support officer can actually trump senior officers. If they identify a guy who has got a problem, they can go to a senior officer and say: 'This guy has got a problem. We need to intervene today.' That sort of stuff. There needs to be no consequence—they got an intervention and this guy has done everything possible; it doesn't destroy his career. In policing, if you expose the

fact that you have a weakness, it's seen as a flaw and they will set about destroying your career, your future and all that sort of stuff.

Senator URQUHART: We've certainly heard evidence in a number of inquiries about the reluctance of police officers and ambos—not so much the fireies—in coming forward because they see it as the end of their career, which they have trained for for a very long time. They love what they do, but they've just encountered some difficulties because of issues that have arisen before. There is reluctance to actually raise issues because they see it as career ending. That's why people tend to hang on sometimes and not actually do that. That's that sort of cultural change I guess.

Mr Folkard: Yes, that cultural change. There needs to be a whole heap of research in that space on what it looks like. I've only experienced the negative side of it. I'd love to say that there's a positive side out there somewhere, but in my own experience I haven't seen it.

CHAIR: Mr Folkard, unfortunately, we're now out of time. I thank you for your submission and your assistance with our inquiry today.

MACCIONE, Mr Brendan, Committee Member, Sirens of Silence Charity Inc.

SINCLAIR, Mr Ian, Secretary, Sirens of Silence Charity Inc.

[14:27]

CHAIR: We now welcome to the table Sirens of Silence Charity. Is there anything you would like to add to the capacity in which you appear today?

Mr Sinclair: I'm a co-founder of Sirens of Silence Charity, a former ambulance paramedic and a former ambulance volunteer.

Mr Maccione: I'm also a WA police officer.

CHAIR: I understand that you've received information on the giving of evidence and the protection of witnesses. We've received your submission, so thank you for that, and we invite you now to make some opening remarks to the committee. That will be followed by some questions.

Mr Sinclair: Thank you. I think our opening remarks are probably best directed towards why the charity exists. The charity exists to represent all three emergency services throughout Australia, their paid and volunteer staff, and to try to capture those people who slip through the existing help nets, the more formal ones, that are in place within the workplace. People do slip through those nets, and they slip through for a number of reasons. Some of those reasons include, in particular, the fear that people have about identifying themselves as having mental health issues or not coping well with particular workplaces and events at work, and the bullying that comes from that, from middle and senior management, that is now almost institutionalised.

These people have all got mortgages, families and it's their absolute fear to lose their jobs. They don't formally identify themselves to their organisations and, therefore, they slip through the net and they don't get the help that they really need. As a direct result of that, certainly within the Western Australian ambulance service, we can easily identify 15 successful suicides in the last 12 years. Roughly seven or eight of those are country based and the remainder are metro based. Bear in mind that country paramedics only represent somewhere around 15 per cent of the paid workforce of paramedic staff in the state, so they're grossly over-represented. Most of the complaints that our charity receives from its members are based around the bullying and lack of support, and the victimisation directed at them from middle-level and senior management.

CHAIR: Thank you. Mr Maccione, do you have anything to add?

Mr Maccione: In late 2016 I was introduced to Lyn and Ian Sinclair, the founders of Sirens of Silence Charity Inc., by attending a 'Dealing with trauma, loss and grief' workshop that they were facilitating along with Road Trauma Support WA. And this was a day that I will never forget.

At this workshop, for the first time in my career, I met other emergency services personnel who spoke openly about their own lived experiences with mental health challenges, to raise awareness of anxiety, depression, post-traumatic stress disorder and suicide prevention within the emergency services. I was immediately provided with peer support and given guidance for pathways to seek further assistance. But, best of all, I was provided an opportunity to sign up as a member and become a part of the charity.

Why is this important for me? I'm a police officer with a little over eight years of service in regional, remote and metropolitan WA. It's a role I've always dreamed of achieving. But my nightmare is that I've seen more death, road carnage, grief and unnecessary acts of stupidity and violence, in those years of service, than the worst horror movie you could ever imagine. In 2017 I was referred to a psychologist for management of my anxiety and PTSD symptoms—specifically, intrusive thoughts from attending multiple serious and fatal vehicle crashes in my capacity as a police officer. My referral was initiated due to my need and desire for additional care, independent from and external to the police force, that would help me progress forward from my PTSD symptoms of stress, fatigue, intrusive images, depression and anxiety.

Treatments for me predominantly addressed my symptoms with trauma-informed cognitive behaviour therapy, CBT, psychoeducation and schema therapy. For the intrusive images I was experiencing, we used eye movement desensitisation and reprocessing, EMDR. This resulted in very positive changes and a reduction in my impact of events scale, my IES score, with it dropping significantly. Through acknowledging my symptoms and my early intervention I've been well-supported by my immediate family, I've been well supported by my colleagues but I've been especially well supported by the Sirens of Silence Charity and Lyn and Ian Sinclair. I've lost long-term friends but, equally, I've made some amazing new friendships through peer support, the community network and trauma-room mental health workshops that I've attended.

My symptoms have improved with treatment and I've linked some of my traumatic experiences to patterns of interpersonal relationships in my early life. The police have been extremely supportive of my recovery. I

acknowledge the support of my colleagues, my supervisors and my officers in charge, both past and present, who've supported me through my duty so far. I accept that the story is different and you've heard differently from many others who have made submissions and spoken of the lack of support they've received. Each of these should be taken into consideration, as I believe that with early identification, acknowledgement and support these stories could be so very different.

I'd like to give Ian a further opportunity to speak on the back of that. I've said a little more than I was going to.

CHAIR: Sure.

Mr Sinclair: I think we all acknowledge that the three organisations of police, fire and ambulance services across Australia, in the last few years, have certainly made some attempts to get better at dealing with what we now know is a significant problem within emergency services. But they've got a long way to go—a long, long way to go. Again, the thing that—again, I underline this—drives the suicide rates amongst those services is the fear, of people being able to seek help and seek the right help, because of retribution, bullying and ostracisation from the various organisations. Some are better and some are worse than others, across Australia. My personal experiences have been with St John Ambulance in WA. They had six inquiries in an eight-year period, and every single one of those identified some major issues, yet we still have the same people steering the ship, and therefore the culture hasn't changed.

CHAIR: The expert advisory group says that they generally believe that 'the work that St John Ambulance have undertaken in providing a multi-model and whole-of-organisation approach of supporting and promoting mental health is very good'. They said that there is 'an emphasis on self-care and also on shared responsibility' and that 'shared responsibility for wellbeing is the responsibility of all, including the organisation. To that end, the organisation has undertaken a culture survey where the vast majority of results were very favourable and they have taken steps to improve where indicated'. So, all seems pretty well at St John Ambulance, according to them.

Mr Sinclair: Yes, 'according to them'. But, Sir, I beg to differ. I would refer you to the Independent Oversight Panel review that was released publicly in August 2016, which states:

… submissions and hearings illustrated a culture where bullying appears to be systemic, if not condoned, and that it does not appear to be consistently addressed.

One officer in a management position reported being told they need to be more aggressive when dealing with Paramedics.

That is a direct quote from page 70 of the Independent Oversight Panel review into St John Ambulance.

CHAIR: I'll put a proposal to you a little bit tongue in cheek, because the evidence the committee's received across the board generally has this massive disconnect to what management structures say is their commitment to delivery and to what actually happens on the ground. I remember—I forget what state it was—tapping the police commissioner on the shoulder as I left the building and asking whether they felt absolutely, 100 per cent comfortable in raising any mental health issues with their direct superior. After a look of shock and horror that I might in fact even do such a thing, he suggested that he'd be disappointed if they weren't able to say that. I didn't test it, but I suspect that the result would have been quite different. So, what still needs to be done? It does appear, in terms of St John, that they've gone through that latest report, which acknowledged a lot of problems, but the summary seems to defy that, to be honest. So, where are we at—it's really just same old same old?

Mr Sinclair: Pretty much, at the moment, yes. I absolutely acknowledge that in particular St John Ambulance, seeing as we're pointedly talking about them, have from a senior management level made an attempt to get better at what is such an important area in any large organisation. And, as with most large organisations, there is a massive disconnect between senior management, middle-level management and lower management. In other words, what decisions get made in the boardroom might get made with all the good intentions, but when it comes to getting horsepower onto the ground it never works or it doesn't work quite as the board imagine it's working. I challenge you to go and tap police officers or ambulance personnel or fire personnel on the shoulder and ask them the question, because I believe the honest answer you'll get on the corner of a street will be very different from what you'll get while they're standing in uniform proudly representing the organisations they work for. And we can't forget that all these people do their job because they are passionate about it. They enjoy it because they're passionate about the role within society and the help that they can bring to other people across the board.

CHAIR: One of the elements we're looking at is how we can make the claims process better and less damaging and more responsive to the needs of the individuals—and, ultimately, the organisation itself to be honest. But that's really a waste of time if there's not an acknowledgement to actually do something about addressing and managing the problem within the organisation as well.

Mr Sinclair: I would suggest that it's the process that lets most people down. I think it can be widely anecdotally recognised that PTSD is a consequence of the type of work these people do. Yet, to make a workers

compensation claim for it and to have treatment—like for a broken arm or a cut finger that you receive at work—is horrendous. It's really a matter of getting all those responsible people, including the insurance companies, to understand that people take on this heavy role, this hard work, within our communities and it is a factual consequence of the work they do. It's not something where they deliberately go and become afflicted with mental health issues; it's a fact of what they do. Therefore, early and easy recognition of that fact would certainly help in the recognition process that we need to help these people get better so that they can come back as valued employees, valued family members are members of our society, rather than be just pushed out the door—because it's easier to get rid of them that way and 'Let's take on the next training school and employ another 50 little robots and push them through the training system.'

CHAIR: Are the emergency services in WA completely separate and standalone agencies, or is there some managerial overlap?

Mr Sinclair: No; they are all completely separate organisations. The fire and emergency services and the police are state government run and administered and fully funded, whereas the St John Ambulance, the recognised first response emergency ambulance service in Western Australia, is a privately owned company. It is a proprietary limited company that receives direct funding to the tune of somewhere between—and I would stand to be corrected—$150 million and $200 million a year from the state government through the health department.

CHAIR: That's hardly anything to run an ambulance service—

Mr Sinclair: Absolutely. The rest of the money comes from co-payment by users of the service. For example, if I were to call an ambulance today and be taken to hospital, I would receive a bill that I would either pay for out of my own pocket or claim through my private health insurance if it was a claimable item.

CHAIR: So there's no levy arrangement?

Mr Sinclair: There is no levy arrangement in Western Australia to support the ambulance service. There is an agreement with the state government that, if a pensioner needs an ambulance, they receive a 50 per cent discount on the cost and the remaining 50 per cent is paid for by the state government.

CHAIR: Is the service provided under a licensing arrangement or could there effectively be a competitor in the market?

Mr Sinclair: It is not licensed.

CHAIR: I know this is digressing a little bit but I just want to understand the structure.

Mr Sinclair: It's empowered through government regulation and, as I said, partly funded through the health department.

Senator URQUHART: It's a contractual arrangement.

Mr Sinclair: Yes, it is a contractual arrangement.

Senator URQUHART: And it has been in place for over 100 years with St John Ambulance.

Mr Sinclair: Exactly. A number of smaller services have tried to start up but they've not been successful, for a number of reasons probably.

CHAIR: Because, depending on the nature of the contractual arrangement, you would think that—the contractor or whoever?—the government would actually be able to impose managerial standards, codes of behaviour and conduct of management on its workforce, and impose those as a condition of—

Mr Sinclair: I don't disagree with you—

CHAIR: But they don't?

Mr Sinclair: I suspect—I've never read the contract and I've never seen the contract. It's closely guarded—

CHAIR: But there's no government oversight of the management of St Johns?

Mr Sinclair: It appears there's not.

Senator URQUHART: My first question is around the practice of self-referral—you talked about that before. How can that culture change around that practice of self-referral for people who are experiencing issues—how they raise that issue and self-refer?

Mr Sinclair: I think it can be made better through a change in culture, driven from the top down as well as from the bottom up, so that there is no way people can be penalised for showing a chink in their armour. All three services wear a uniform, and proudly wear that uniform, and we're seen by the public as superheroes in most cases—except, perhaps, when you're getting a speeding ticket! They call us in their time of need, and that's how the public perceives us. It's really hard to have someone come along and say, 'I've got a problem in handling some

of this work,' because management at all levels turn around and say, 'Well, if you can't handle the work, don't do the job.' It's not quite that simple.

Senator URQUHART: No. Should there be mandatory counselling sessions?

Mr Sinclair: My personal belief is yes, absolutely. There should be mandatory counselling sessions, in particular—

Senator URQUHART: And when should they occur?

Mr Sinclair: I believe they should be annual, and in particular for police and frontline ambulance personnel. And including the call centre personnel, because they're often the forgotten people in those two services in particular.

Senator URQUHART: Yes.

Mr Sinclair: They're dealing with people in crisis on the end of the phone—they're screaming and yelling and almost incoherent—

CHAIR: Sorry to interrupt, Senator Urquhart, but do the fire services in WA act as first respondents for medical conditions too? I know that in some states they actually do first aid.

Mr Sinclair: They generally have first-aid-qualified people on the trucks, but that's not their role at any emergency. Their role is purely fire control and suppression, as well as emergency extrication from vehicles and/or buildings. The primary role of first aid falls to the Western Australian Ambulance Service.

Senator URQUHART: In your submission you went into a lot of detail about bullying, and issues around bullying. Can you step us through how you and others have sought to work through that bullying issue within the St. John system, I suppose, or management, or however you work through that process?

Mr Sinclair: In this instance I'd rather talk about my own personal interactions, because that's what I know. Then I'm not also revealing the identity of other people.

Senator URQUHART: Yes, of course.

Mr Sinclair: In my own instance, I attended a job that involved the very traumatic death of a two-year-old and a very long, drawn-out resuscitation process. Within 12 hours of that event a colleague of mine released my name to family members and to the general public, that I was involved in that job and that they should come and have a talk to me. That's strictly prohibited under our regulations. I got a bit angry with the guy, and said: 'You can't do that. Don't do it, and don't ever come and talk to me again about this particular case.' He reported me to management. We were by then, in terms of time, just under 24 hours after that incident. I was suspended, I was forbidden, in writing, to contact any of my peers, I was not to discuss the case with anybody at all, I was living in a caravan 600 kilometres from my family and I was not allowed to leave town to go to my family. It took nearly two weeks of appealing to management to allow me to leave town and go to my permanent home with my family. They would not listen, regardless of how high I took my complaint and how loud I yelled, they would not listen to the fact that I felt extremely isolated and bullied and I needed some support. They just don't listen.

Senator URQUHART: Did you ask for support or was any offered after that incident.

Mr Sinclair: Six weeks after that incident I was still on suspension, and I said, 'I need some help.'

Senator URQUHART: But not immediately?

Mr Sinclair: Not immediately. My permanent home was Broome, and the help that I got was over a period of about another week or ten days—three phone calls from a health and wellbeing officer, and that's it.

Senator URQUHART: And that was based in Perth?

Mr Sinclair: Perth based, that is correct. And Broome, in case you didn't know, is 2,200 kilometres north of Perth.

Senator URQUHART: It's a very long way away.

Mr Sinclair: Absolutely. I was suspended for a total of 128 days and was absolutely exonerated. It was found I had no case to answer.

Senator URQUHART: What was the reason for the suspension.

Mr Sinclair: The person who divulged my name to the public felt that I had spoken to him in an intimidating way. It took 128 days to find out that I didn't.

Senator URQUHART: But in that process you didn't have any support?

Mr Sinclair: I had none.

Senator URQUHART: As a result of either the standing down or, in fact, the incident that you'd attended.

Mr Sinclair: Exactly, and for me personally it was the fact that I couldn't talk to my peers. The incident involved a significant number of senior doctors and staff from the local hospital. They all had multiple debriefing sessions about the incident and I was forbidden to take part in any of that.

Senator URQUHART: Okay. I now understand the bullying stuff. I want to talk about the reviews. Thinking about the reviews and your experiences, what are some of the immediate changes? In relation to Senator Marshall's questions about some of the recommendations in there, I note there was one that they didn't respond to. What changes do you think could be made to have the greatest impact for first responders?

Mr Sinclair: I'm acutely aware that my testimony is public, but, having said that, the first thing that needs to change are some of the managers within, in particular, the Country Ambulance Service.

Senator URQUHART: Are they St John as well?

Mr Sinclair: They are St John Ambulance.

Senator URQUHART: It's all St John?

Mr Sinclair: Absolutely, yes. For example, the current manager of Country Ambulance Services has been in that position for, I'm guessing, 12 to 15 years. He has a de facto relationship with the director of human resources—I'm not sure what they call that department nowadays; it has recently changed names—and there is no question that, unfortunately, because of their relationship they form an opinion about particular officers. Whether that opinion is right or wrong is kind of irrelevant, because, whatever that opinion is that is exactly what happens and plays out within the workplace. As a consequence of that, all the managers that sit underneath the manager of country operations are just as toxic. That needs to change. There's no question that there is evidence that for all the suicides that have occurred within the ambulance service—in particular the suicides that occurred with country staff—they all had very recent interaction with those managers at the Country Ambulance Service. One of those paramedics committed suicide minutes after a meeting where she was not allowed to have, or didn't have, a peer support person with her. She was handed a pretty onerous document and within minutes she'd walked out, made the decision and carried out suicide.

CHAIR: Just on the basis that you acknowledge that your testimony is public, and it is, and the inference that people might not like your testimony—let me just again put on the record now that it is unlawful for anyone to threaten or disadvantage a witness on account of evidence given to a Senate committee, and it is something the Senate takes incredibly seriously. If you believe that you have been disadvantaged in any way by the evidence you give, you must report that to the Senate and the Senate will deal with it. I put that on the record now.

Mr Sinclair: Thank you. I appreciate that, but I'm no longer an employee of the ambulance service. I retired just before Christmas last.

Senator URQUHART: In relation to the country ambulance areas, obviously Western Australia is quite vast, so it reaches out into very remote areas. I've spoken personally to a number of ambulance personnel here in WA a just a few weeks ago actually; I was here for another hearing and I took the time to go and have some valuable time talking to ambulance operators, while they were on the job, ramping in hospitals and those sorts of things. I also was lucky enough to talk to some remote country wide ambulance people via a videoconference link. From what I gathered there, there a number of stations where the personnel are employed full-time people but there may be one person within that sort of arrangement and then they are backed up by volunteer ambulances within those areas, and in some areas there are a number of country ambulance volunteers that actually operate within that system. I know some of the frustrations with the workload and the ability to have breaks and also the bullying process from St John to even people way out thousands of miles away.

Mr Sinclair: Absolutely.

Senator URQUHART: Have you experienced through your representation of people those sorts of incidents as well?

Mr Sinclair: Yes, I have. I have worked in those remote locations. For the benefit of the entire committee, Western Australia, in the metropolitan area, Perth, is all paid staff—paid paramedics and ambulance officers, and an ambulance officer is a paramedic in training, for want of a better word. In rural WA, there are a few stations that have a number of permanent staff that are supported by an even larger number of volunteers. For example, in Port Hedland, where I was working for five years, we had seven permanent staff and depending upon which week anywhere from 30 to 50 volunteers on the books that helped us run the service. In most rural communities in Western Australia, the ambulance service is run by volunteers only within that town, and they are supported by a

single community paramedic that might service up to half a dozen towns. That's how the ambulance service runs in Western Australia.

Senator URQUHART: Do you have any suggestions on how the return to work workers compensation officers could be more supportive of workers compensation claims, particularly around mental health? Do they need more training; different management, which you've touched on; independent organisations? How could that actually be done better?

Mr Sinclair: 'Meaningful tasks' are the two words that scream out to me. Anybody in the ambulance service—I can't speak for WAPOL or fireys—who is on a workers compensation return to work program at the moment, whether it's from a cut finger, a broken leg, surgery or mental health issues, are grouped together, put in a little office at the bottom of the building and if they're given any tasks they are given menial tasks of folding this, envelope-stuffing this, running an errand here or delivering medications and drugs to some of the depots around the metro area. They're not meaningful tasks. They're not engaging. They're not mentally stimulating at all and, for someone with mental health issues, there could be nothing worse. So, yes, some meaningful tasks and overseeing of that return-to-work process by professional people—and that immediately says to me that the professional people should be external to the relevant organisations so that people are getting the right help not only for their cut finger but for their mental health as well.

Senator URQUHART: Mr Maccione, I'm conscious that you're sitting there and I'm not directing questions at you, but I'm happy for you to jump in if you've got some suggestions about how you think things could be improved from the police perspective. Are you still an operating police officer in WA?

Mr Maccione: Yes, I am. How I'd like to see us get there—and when I say 'us' I don't just talk about the police; I talk about emergency services in general—is through easy access to treatment. A recent example was that one of our Sirens members needed crisis care, and the admissions paperwork had basically stalled with the insurance company. That paperwork not being submitted stopped that person from being admitted.

Senator URQUHART: So why did that not get submitted? What was the hold-up?

Mr Maccione: I don't know, for that specific circumstance, what the hold-up was. What I can say is that the Sirens of Silence charity was very quick to become involved after hearing of that and was able to provide immediate admission to the hospital at cost to the charity, if needed. Miraculously, some paperwork turned up from the insurance company.

Senator URQUHART: I've dealt with worker's comp over a number of years. I've been a union official for 20-odd years prior to me doing this. I know one of the issues is around paperwork and stalling and for people to try and get help as quickly as possible, not just for mental health but for other issues as well. I always used to run the analogy that, if you fell over and broke your leg or twisted your ankle when you were playing tennis, you'd go to your doctor and probably get in to see a surgeon immediately, but for worker's comp it's months and months and months down the track. There seem to be too many questions and too many fights and arguments about who's going to pay for it and who's going to do it. So I suppose that's a big issue, particularly around mental health issues because of the consequences.

Mr Maccione: Absolutely. Sorry to cut you off. We're talking about people in a crisis situation—people who have the means and the ability to take their own lives.

Senator URQUHART: Yes.

Mr Maccione: For me, there's no greater immediacy required than that circumstance right there. We shouldn't be stalling on paperwork. If we have somebody in a crisis situation, we should absolutely help them.

Senator URQUHART: Yes. I'm just looking at our terms of reference. One of our terms of reference was collaboration between first responder and emergency service organisations. Does that happen in WA to your knowledge? Do you have good collaboration between the different services? Do you look at whether someone has a best practice model and whether that is something where, rather than reinventing the wheel, we can actually sit down and have a good discussion about how we can help our comrades in another area? You can both have a crack at it if you want to.

Mr Sinclair: One thing that the services are very good at is ownership, and they do not want to share ownership of any of their good ideas. I am aware that there is a semiformal meeting of WAPOL, SJA and FESA—Fire and Emergency Services. They have a cup of tea occasionally, but there is no formal sharing of best practice. That's evidenced by the fact that there is a vast difference in the way the three organisations treat injured workers, be it mental health or otherwise. So there is no sharing of best practice at all, and that should be a starting point.

Senator URQUHART: It doesn't seem to make any sense, does it? If someone does it well, why is that not used?

Mr Sinclair: No, it makes absolutely no sense at all. If I may just momentarily step back to your question about paperwork being held up, it's usually held up by insurance companies because they are reluctant to take responsibility, because the minute they do they then become liable for the entirety of the repatriation process.

Senator URQUHART: Yes, that's right.

Mr Sinclair: Money being what it is, insurance companies don't like parting with it, and that's why they are very recalcitrant in the way they deal with workers compensation claims—in particular when it comes to mental health. Because you don't have a broken arm or something as visual as that, they require a huge amount of proof to take responsibility.

Senator URQUHART: It's a false economy, though, isn't it? Sometimes, if the issue is picked up early and dealt with, it could be a lot less costly.

Mr Sinclair: You and I aren't in the insurance industry, and we can see it. I am dumbfounded that they can't.

Senator URQUHART: Absolutely, yes. Mr Maccione, do you want to add to that?

Mr Maccione: My comment from that frontline perspective is that some of the best interactions that we have between the services are when the feet are on the ground. You're at a horrific crash scene, and I can tell you it's every person doing a job to work together to get the job done.

Senator URQUHART: You work together, yes. So why doesn't it happen at a higher level? I know that's a really dumb question, but why does it not happen?

Mr Maccione: I would suggest ownership—ownership of the problem.

Mr Sinclair: I would say best practice.

Senator URQUHART: The logic would tell me that, if I had a best practice or a good idea, I would love to share that with other people. If it helps somebody, isn't that a good idea?

Mr Sinclair: I think part of the problem comes from the fact that the three organisations are run very separately. There is no overseeing person or body of the three organisations, and that's made worse because the ambulance service is a privately owned organisation.

Senator URQUHART: Which is unique to WA.

Mr Sinclair: Which is unique to WA. They run the largest ambulance service geographically in the entire world. They rely heavily on the government contribution of a couple of hundred million dollars a year, but they're very reluctant to share or receive any best practice advice from anybody. That's a crying shame, and I think the only way around that is to somehow, through legislation or via the chequebook, force the three organisations to share their best practices, set some goals and work to get better at what they should be doing naturally anyway.

Senator URQUHART: Yes. Take the presumptive legislation for firefighters for cancers. Senator Marshall was instrumental in pushing that through a Senate inquiry, and eventually that led to many of the states picking that up for firefighters. I understand that was something international that came out Canada and places like that. I would have thought that it made sense to look at what the best benchmarks and examples are from anywhere and then look at how we could apply them across here. I know Western Australia is quite isolated compared to the rest of Australia, but do you think that there is space and room for national, if not international, collaboration around some of these issues and how they're dealt with?

Mr Sinclair: I would give a very loud and strong yes.

Senator URQUHART: Are there good examples that you know about either nationally or internationally that you would raise?

Mr Sinclair: I so wish I could give you some, but I can't, because I don't believe it properly exists. There is a meeting between all the CEOs of all the ambulance services once or twice a year, but they don't discuss those sorts of things. They don't have those sorts of things on their agenda, let alone having high-level discussions between organisations about their best practices in how they deal with sick and broken staff members, and the economics that they can actually gain by fixing broken staff members rather than training new ones.

Senator URQUHART: They could actually have more staff to do more work, which would lessen the load.

Mr Maccione: In many of my experiences with PTSD, anxiety and depression, I've opened myself up to a broad range of things that are available on the market, including internationally. I can tell you that there are some international places that I've had a look at. There is in the US an organisation called Code 9, which has done some remarkable work in ensuring that first responders suffering from PTSD, anxiety and depression are looked after

and compensated within their own schemes. A bill was passed in Florida within the last six months that I'm aware of, just through reading their Facebook group.

Senator URQUHART: Good. We had the firefighters from Canada at, I think, our Brisbane hearing. The stuff that they've done is pretty mind blowing compared to where we're at, so I think we can learn from that. Thank you very much.

CHAIR: That's all we have time for, so thank you both very much for your contribution to our inquiry.

Proceedings suspended from 15:10 to 15:53

CONGDON, Ms June, Member Support Officer, United Voice

FITZPATRICK, Mr Scott, Ambulance paramedic, Western Australia; and Delegate, United Voice

HIPWORTH, Ms Sarah, Ambulance paramedic, Western Australia

O'DAL, Mr Patrick, Ambulance paramedic, Western Australia; and Delegate, United Voice

O'DONNELL, Mr Patrick, Ambulance paramedic, Western Australia; Assistant Branch Secretary, United Voice (WA)

STUART, Mr Victor, Ambulance paramedic, Western Australia

CHAIR: I welcome representatives of United Voice Western Australia. I remind all witnesses that in giving evidence to the committee they are protected by parliamentary privilege. It is unlawful for anyone to threaten a witness on account of evidence given to a committee and such action may be treated by the Senate as a contempt. The Senate takes such allegations incredibly seriously and will investigate any such claims.

We have received your submission, No. 86. I now invite you to make some opening remarks to the committee, to be followed by some questions.

Mr O'Donnell: We appreciate the opportunity to appear today. United Voice is the union that covers paramedics in WA. Essentially, St John Ambulance is the contractor for ambulance services in WA and has an effective monopoly on that work in Western Australia. The reason we're appearing today is we think the provision of ambo services really goes to the core of government responsibility. With an essential service such as ambulance, even in the situation where the service is contracted out, it is still ultimately the responsibility of government to ensure not only that that service runs efficiently but also, I think, that the people who do that work for the community are adequately supported. The reason we're appearing today is we think the provision of ambulance services really goes to the core of government responsibility. We think that for essential services such as ambulance, even in the situation where the service is contracted out, it is still ultimately the responsibility of government to ensure not only that the service runs efficiently but also that the people that do the work for the community are also adequately supported.

St John have got a monopoly. They've been in WA since 1922. So it's been a significant amount of time. As first responders, ambulance officers are inherently exposed to traumatic and often dangerous incidents throughout their careers, and very significant things that the ordinary person is unlikely to face in their lifetime and certainly not in an ongoing way. They not only deal with violent crimes, road trauma and horrific accidents but they also deal with the public and an increase in violence towards them as well. The point here is that these stressors are over and above the normal routine ones that you might face, such as fatigue or workplace conflict. They're in a role that's got significant stressors.

If you talk to paramedics in the service they are without doubt that the work that they do leads to negative impacts on their own wellbeing. I think that's to varying degrees, but I don't think I've spoken to a paramedic in the four and a half years I've been working with them that hasn't said that their job has impacted them to some extent. Obviously, we're aware that some have been impacted the point where they've taken their own lives. I wanted to bring your attention to the fact that while we, and paramedics, take this as being a given, that is not a view necessarily shared universally. I think this is a substantial problem, and one which I'd like the committee to consider. Governments need to take a stance on whether or not they support the idea that the work of paramedics inherently leads them to greater negative health outcomes than the general public.

I'd like to draw your attention to a report that was given to St John by the expert advisory group and I think it has been given to you. The executive summary on page 4 makes these two points that I'll read:

- There is a lack of clear evidence that ambulance workers have higher rates of suicide than people in other occupations, or that suicides completed by emergency medical responders are because of factors pertaining to their work
- Rates of mental illness / psychopathology in ambulance personnel appear to match prevalence rates of psychopathology evident in general populations but tends to differ depending on the service. This likely reflects the various models of staff support, psychoeducation, and organisational culture with regards to attitudes to mental health

I guess it's in contrast to others who've been much more strong in pushing the point that actually there is an impact. Even the Victorian CEO of Ambulance Services quotes that there's four times the rate of suicide amongst ambulance staff than the general population. I think it's three times higher than other emergency service personnel, such as police and fire services. That was based on the Victorian statistics. So one of the things that I think government must decide on and take a leadership role on—because I believe it impacts everything else—is

that paramedics, first responders, police and fire brigades have stressors inherent to the job which do lead to negative mental health outcomes. I think that should be said and needs to be acknowledged by government.

Our first recommendation is that there is formal recognition from all governments that front-line emergency service workers can suffer adverse psychological effects from trauma experience at work. That's one of our first things we think needs happen. The second is that there is no ambulance legislation in WA. Many states do have legislation or their service is legislated. There's no recognition of ambulance as an essential service, there's no policy you can point to that just talks about the service in WA as an essential service. Essentially it's run between a contract between St John and the state. That contract is really very simple and it sets very basic KPIs around attendance at jobs, but that's about it. It doesn't go on to put into the contract the responsibilities that we would expect the employer to have, or the government to take, on service provision to the community, the quality of care provided and the health and wellbeing of the workforce, and we think this is something that needs to be addressed.

On a positive note, we know the state government have indicated they intend to work on a contemporary contract, which we're encouraged by, but it's taken a long time to get the attention of government. Whether it be in WA or anywhere else, we think government oversight of the services is something that needs to be in place. So we've suggested that the state governments ensure that key performance indicators and reporting are sufficient and appropriate to hold ambulance service providers accountable for ensuring a quality ambulance service, including the health and wellbeing of their employees. Without the key performance indicators, I'm not sure how government holds the service to account. Certainly from a union perspective and for the workers and members that we represent, it leaves us solely trying to argue with an employer when the overarching oversight should also be with government.

A key thing we think needs to be considered is presumptive legislation, and I say this for a number of reasons. Once again, I think presumptive legislation gives a validation that PTSD is a workplace injury, and it would help overcome some of the difficulties that people find in going through the workers compensation process. Even though workers compensation is in place and statistically there may be a reasonably low number of cases which are refused, we know that a lot of people avoid going into the workers comp process altogether and will instead go down other paths such as salary continuance insurance or using their personal leave. We think having presumptive legislation would be a significant change in acknowledging that the cumulative stress of the work can result in a mental health injury and would also encourage employees to take more preventative measures to avoid falling into that situation.

The final two recommendations we put are that the Commonwealth government work with all state and territory governments to introduce uniform presumptive workers compensation laws that benefit ambulance officers who develop PTSD as a result of performing their duties and that all governments ensure that the compensation process for a person who's affected by mental health conditions does not exacerbate the condition of the individual concerned. I think the other problem you have without presumptive legislation is that you're required to relive your situation as you go to prove over and over again to insurance companies or to your employer why you should have a claim processed. Doing that causes further harm to the people who are needing support. Presumptive legislation would enable people to get support more quickly and have less trauma involved in processing their claims, and a rebuttable presumption would still enable insurance companies or employers to argue if there was clear evidence to suggest that it wasn't the work that had been the cause.

Those are the three main themes that we wanted to talk to you about today, but of all of them we think government oversight and clear KPIs about what is expected of the service, whether it's run by government or by a contractor, would be very useful for helping paramedics improve both their health and wellbeing and also the service delivery to the public.

CHAIR: Thank you. Well, we have very limited time. Senator Urquhart, do you have some questions?

Senator URQUHART: Yes, I do. In relation to the report that was done, *Review of St John Ambulance: health and wellbeing, and workplace culture*, I noticed that recommendation 24 is the only recommendation that was not adopted: to revisit the contract with the state government to 'incorporate agreed key performance indicators relating to the psychological risk and care of the workforce'. What changes would your members like to see in regard to the contractual relationship and the responsibilities of both parties as it nears its centenary? I think St John have had the contract for about 100 years. What do you think needs to be adopted and changed?

Mr O'Donnell: I'm happy if anyone wants to add anything to this at this point in time. Essentially, there need to be KPIs put in place where the government is actually setting the contract, not the contractor self-managing. That's what we have with St John at the moment: they have the expertise in the area in WA and they've more than just got a contract to perform a service. Essentially, the responsibility for service has been contracted out to the

contractor. When it comes to health and wellbeing, the government needs to be setting what they think are the appropriate measures and the appropriate standards in place, and then expecting the contractor to work towards those. There are a number of things which have also not been adopted—one would be trauma tracking, for instance. I think it's unlikely that St John, as the contractor, is going to adopt that, and I'm sure there's a process that would need to take place to enter into something like trauma tracking, but it's the role of the government to determine whether or not that is a requirement on the contractor to do. So, using that as an example, the government needs to take a role in setting those standards. If it was trauma tracking, for instance, that needed to be done, then the government should be putting that into their contract and requiring them to do it.

Senator URQUHART: You talked about a contemporary contract, and that's what you understand is happening. What does that actually mean?

Mr O'Donnell: My understanding of what that means is that they've got a contract which has been in place for a very long time that lacks detail. I'm also aware that there's a WA Country Ambulance Service review which, I think, will be imminently released as well, so it's an opportunity for the government to have a look at what's actually in the contract and start to build in some greater measures: not just for health and wellbeing, but for service delivery. Because the thing is, particularly for areas like the country, where there is a volunteer model in place, the government needs to take a more active role in ensuring that it's delivering the outcomes for the public. Because I'm not sure that the public are aware of the extent of the volunteer model.

Senator URQUHART: In relation to reporting of mental health issues, I presume that there's a reluctance to do that, and I think you talked about that in terms of the presumptive legislation. Is there a role for mandatory counselling after a particularly traumatic event? Do you see that as something that could happen, or should it all be a self-referral? In some cases, we've heard evidence in other places where that's unlikely to happen because people are unsure about how that will impact on their role into the future and whether they'll be persecuted as a result of that. We've heard evidence in a number of states where people fear for their role into the future and their job, because if they say they've got a mental health issue, then they see that that might impact on their future.

Mr O'Donnell: There are so many different aspects that can be put in place around health and wellbeing. To talk to that one specifically, I think there would have to be consultation with a range of people before you would do that, because I realise there are consequences for going down that model. Ultimately, we have to put people's health and wellbeing first. I think there would be people who, as a consequence, would be found not to be suitable to continue to work, and that's one of the fears that people have. But, ultimately, your job comes second to being alive and your health and wellbeing. We've got to balance those things. But, once again, government should be the entity that ultimately determines whether that's the course of action to take. In many industries, when you subcontract work out or you contract work out and you leave it to the employer, you can say, 'Well, there's OSH legislation in place, and we leave it to the employer to do the right thing.' In some cases that can work, but when you've got an essential service—and that's the key thing: this is an essential service that the government must provide, and it's of particular importance to the community and to the people who work in it—the government has to take a more proactive role in ensuring that what's in place is best practice, and that it's not just putting that out completely for the contractor to determine. So, on that particular thing, I wouldn't commit to say that that's an absolute must have. But, certainly, I don't think that's something the employer's currently going to do. So, if that were something that our membership supported, we would certainly need the government to do it, because it wouldn't happen otherwise.

Senator URQUHART: We are running out of time. I've got some that I might put on notice later on. Western Australia is unique in having a contractual arrangement as opposed to emergency services, particularly ambulance, being provided by the state government and employees of the state government.

Mr O'Donnell: Yes.

Senator URQUHART: I guess the issue is always around staffing and numbers. Are there enough paramedics in various areas to allow for respite, rest and time out in between—

Unidentified speaker: Safe work.

Senator URQUHART: Yes, safe work in between traumatic experiences but also just as a matter of course.

Mr O'Donnell: I think the simple answer to that is no.

Senator URQUHART: I thought you might say that, but I wanted to ask.

Mr O'Donnell: Yes. No.

Mr O'Dal: I'm happy to go on the record with specific information about country stuff.

Senator URQUHART: That would be really useful. Thank you.

Mr O'Dal: Obviously I've more recently worked in country WA as a community paramedic, and my job in that role is to look after quite a big area of the country. I had an area spanning about 250 kilometres east-west and about 150 kilometres north-south, looking after 10 ambulance centres and 235 volunteers. On top of the normal stressors of ambulance work, which you've already heard about, our position description as community paramedics factors in a whole lot more. I can probably table the position description.

Senator URQUHART: If you're able to table that, that would be helpful.

Mr O'Dal: Yes, you can read over it. It's quite immense. There's only one per area.

Senator URQUHART: One paramedic?

Mr O'Dal: One community paramedic for that whole area, and you're the only trained paramedic. Everyone else is a volunteer. So you go for any job that is above what a volunteer would normally be expected to handle. You get calls 24 hours a day, seven days a week. You never have any downtime.

Senator URQUHART: You live in that community as well, I guess.

Mr O'Dal: You do. You live in the community. You're usually personally affected by all the jobs that you go to or there's some sort of personal connection, not just at the time but ongoing, and there's absolutely no relief. There's not one community paramedic place in WA that has two community paramedics working back to back so that you can have some downtime.

Senator URQUHART: So you're on your own.

Mr O'Dal: They're all single responders.

Senator URQUHART: So when do you have days off?

Mr O'Dal: As an example, you might turn your phone off for a couple of days.

Senator URQUHART: You're a paramedic. You can't do that, surely.

Mr O'Dal: Well, if you do and something happens when your phone's off, how do you think you'll feel?

Senator URQUHART: That's what I'm saying.

Mr O'Dal: It could be your friend's kid that has drowned, and they'll ask you why you didn't pick your phone up. That stress is insurmountable. It's nearly superhuman to have to fulfil that role as well as being the only trained paramedic.

Senator URQUHART: How often are community paramedics stationed in areas? Do you have a rotation or move around?

Mr O'Dal: No.

Senator URQUHART: So you're there for life?

Mr O'Dal: There are some permanent people that have been there for a while. St John have recently, I think, put a 24-month maximum period onto it.

Senator URQUHART: Thank you.

CHAIR: Unfortunately, that's all we have time for. If there's anything that you feel you need to contribute further or there's information you've taken on notice, please feel free to provide that to the secretariat.

Senator O'NEILL: Chair, can I put one on notice.

CHAIR: Yes.

Senator O'NEILL: We've heard evidence in other contexts about the really serious challenge of moving into another career when this is what you've invested your whole life in. The responses were that it's really important that we keep skilled people. What the solution to that problem? For some people, staying is not the right option. It makes everybody else unsafe. It's bad for them. Have you given any thought to what happens when this is no longer a job that you can do? What would better practices look like? Is a shorter career necessary for some people? I am asking about that area in general, because clearly you care about it. You know a lot about it. What thought is being given? What is best practice? Do you know any jurisdictions internationally that seem to be doing this better than anyone else, or is there a solution that's cooked up here? In that area, if you could put a little bit on the record for us, that would be great.

CHAIR: Again, thank you very much for your contribution to our inquiry.

CLARK, Mr Tony, Acting Director of Human Resources, Western Australia Police Force

HIGGINS, Inspector Jane, Inspector, Health and Safety Division, Western Australia Police Force

JACKSON, Ms Deborah, Director, People and Culture, St John Ambulance WA

LAWRENCE, Mrs Donna, Wellbeing and Support Manager, St John Ambulance WA

McCABE, Mrs Lindsay, Manager, Workers Compensation and Injury Management, Department of Fire and Emergency Services, Government of Western Australia

ROBERTS, Ms Karen, Director, Human Resources, Department of Fire and Emergency Services, Government of Western Australia

SMITH, Ms Anneliese, Manager, Wellness, Department of Fire and Emergency Services, Government of Western Australia

[16:16]

CHAIR: I welcome representatives from the Department of Fire and Emergency Services, Western Australia Police Force and St John Ambulance. I understand that information on parliamentary privilege and the protection of witnesses and evidence has been provided to you. I remind witnesses that the Senate has resolved that an officer of a department of the Commonwealth or a state shall not be asked to give opinions on matters of policy and shall be given reasonable opportunity to refer questions asked of the officer to a superior officer or to a minister. This resolution prohibits only questions asking for opinions on matters of policy and does not preclude questions asking for explanations of policies or factual questions about when and how policies were adopted. Officers of the department are also reminded that any claim that it would be contrary to the public interest to answer a question must be made by a minister and should be accompanied by a statement setting out the basis for such a claim. It would be unfair, I guess, if we tried to do that today, in the absence of any ministers, but we'll jump that hurdle if it arises. Of course that doesn't apply to officers of St John, who aren't officers of the Crown, as I understand it.

We have received your submissions. I now invite you, in turn—I don't know if you've worked out who wants to go first—to make some opening remarks to the committee, and they will be followed by some questions.

Mr Clark: Can I start off by thanking the committee for the invite and for taking the time to consider this important issue of mental health conditions in first responders. To give you some background—obviously, you've had our submission—I will touch on just a few things.

WA Police Force employs some 9,000 police officers, police auxiliary officers, Aboriginal police liaison officers, public servants and other specialist staff. We have 158 worksites, and we cover over 2½ million square kilometres of policing jurisdiction. WA Police Force accepts that working in a first-responder environment can be and is often highly stressful and requires staff to face unpleasant and traumatic situations. This is true for police officers as well as for other staff such as call takers, who may be on triple 0 calls; analysts who are looking at information that might come in to the police; or even front-counter staff who work at police stations. Factors which can affect how people respond to these situations, we believe, include wellbeing strategies; workplace culture; support mechanisms for those who are facing these stresses, and that includes family and friends as well as the workplace; their personal health, including physical and mental health; and predisposition related to psychiatric health.

WA Police Force recognises that its staff can and do suffer adverse psychological effects from situations they face at work. To deal with the potential for people to suffer adverse psychiatric effects of trauma, WA Police Force undertakes a number of things, including the following. We select appropriate staff. That means we have a selection process which will include, for police officers, psychological testing. Where people may face increased traumatic events, we also undertake extra psychological assessments, and this includes specialist areas such as child abuse areas, road traffic areas and those kinds of areas.

We encourage staff to maintain their own health through wellness programs. We have a very vibrant and active Fit for Life program, which includes the provision of gymnasiums and other health related programs. We provide support for psychological wellbeing and preventative programs, including resilience training, and we have peer support. We try to identify and support people who may be suffering from psychiatric or physical conditions, and as part of that we attempt to normalise the support, reporting and identification of psychiatric problems to minimise any stigma that might be associated with them.

We also have a dedicated health and safety department, a dedicated welfare service and also a chaplaincy service. We provide access to staff support through employee counselling, access to psychiatrists and access to psychologists as well as workplace counselling services and services for officers' family or staff's family. We as an agency pay for all reasonable work- and non-work-related medical expenses including physical and psychiatric medical expenses, and police officers have access to significant paid sick leave provisions.

Police officers are not deemed as being employees under the WA Workers' Compensation and Injury Management Act 1981. They're appointed by the Crown and therefore aren't covered by the workers compensation act. We effectively run an in-house self-funded workers compensation scheme. There are differences between the state workers compensation scheme and what we provide. On the whole, it's a very similar provision. In some areas it's better; in some areas it's worse.

We also provide access for former police officers under the Police (Medical and Other Expenses for Former Officers) Act 2008. This includes entitlements which are entirely consistent with and in fact exactly the same as the workers compensation provisions. So officers who have been injured in the course of their duties who leave the agency are able to claim effectively the same entitlements under a workers compensation scheme, and that scheme is managed on behalf of the Commissioner of Police by the ICWA, the Insurance Commission of WA.

The WA Police Force, however, does not treat people with PTSD or psychiatric illnesses. Our provisions through our health and safety services are to encourage people to use their own medical services and for us to pay for those services on their behalf.

WA Police Force also works closely with other first-responder agencies and the WA Mental Health Commission to pool experiences and learn from each other. WA Police Force also engages with and is very supportive of the work and dialogue it engages in with the WA Police Union and the Medically Retired Western Australian Police Officers Association. In many respects, the three organisations are working towards the same goals in relation to these problems. We may have different views on how we do that, but I think we're all working to the same goals.

However, WA police cannot say that there is not still a lot more work that needs to be done in this area. We do, however, continue to be cognisant of current research and supportive of treatment plans by access to medical expenses, and attempt to change workplace culture through education and support networks and prevention strategies. Thank you.

CHAIR: Thank you.

Ms Roberts: Like my police colleague, I'd like to thank the inquiry for giving us this opportunity to talk about this important issue. Further to the information provided in our written submission to the inquiry, I'd like to briefly comment on the work being undertaken in regard to addressing the organisational culture and dynamics which are reported as being either a risk or a protective factor, depending on the organisational disposition, in regard to leadership and management influences on creating psychosocial safety in the workplace. I would like to acknowledge the contribution of Dr Peter Cotton and his work in highlighting the importance of leadership style, leader role modelling and behaviours, and work and team climate as core measures for the prevention of psychological injury and PTSD. This is particularly relevant to first-responder organisations, where the combination of negative organisational experiences and operational incidents increases the occupational stress.

The research recently undertaken by the Bushfire & Natural Hazards Cooperative Research Centre on the prevalence and predictors of mental health in firefighters, which involved four Australian fire services and 335 career and volunteer firefighters, found that, while greater exposure to traumatic events in the previous 12 months was a predictor for depression and PTSD for career firefighters, it was actually low job satisfaction that was attributed as a greater contributor to the variations in depression, PTSD and alcohol use than other occupational exposures.

DFES is engaged in building a more collaborative and inclusive organisation, investing in the development of staff and volunteer leadership capabilities in particular. This includes devoting more time to the development of people management skills through formal learning and development pathways; increasing the understanding of responsibilities and best practice around preventing and managing inappropriate workplace behaviour; the review of recruitment, promotion and transfer decisions; and embedding performance management development practice to support quality employee engagement. DFES is committed to evidence-led strategies and programs. Following the recent evaluation of our chaplaincy services, we'll be evaluating the end-user experiences of our Employee Assistance Program, which is available to all of DFES staff, our local government bushfire service volunteers and their immediate families, as well as our retired career firefighters.

Whilst these comments relate largely to preventative measures, in closing I'd like to comment briefly on the arrangements and experiences of our employees and volunteers in regard to workers compensation, or personal accident insurance as it relates to our volunteers, in regard to claims for PTSD. I understand that, in some jurisdictions and services, workers have reported that the process of making a claim has been adversarial, invasive and traumatic. DFES have worked closely with our insurer, RiskCover, over the last six to seven years to minimise the stress and anxiety for workers making a claim for PTSD. Since 2010, our insurer has accepted liability for all PTS claims lodged by first-responder workers. Our insurer will also fund preventative therapies on a without-prejudice basis before determining liability. Thank you.

CHAIR: Thank you, Ms Roberts.

Mrs Lawrence: Once again, thank you for the opportunity to appear before the committee today. St John Ambulance Western Australia is a not-for-profit organisation that is contracted by the Department of Health to be the primary provider of paramedic services within Western Australia. This is a service St John has provided to the Western Australian community for over 100 years.

St John services the entirety of Western Australia through paid career paramedics; in regional areas, by a combination of paid paramedics and volunteer support; and, in remote areas, by volunteers with support by a paid community paramedic. St John has approximately 1,500 paid employees and approximately 8,000 volunteers. The on-road first responders are supported by the St John State Operations Centre, which is staffed by communications officers. These are the individuals who answer the triple 0 calls and are considered as part of St John's first responders.

St John recognises that mental health issues and injuries are a significant and ongoing issue for society generally and for first responders, including St John employees. While the research available to St John has not identified a greater prevalence of mental health issues within first responders as compared to general society, St John considers that every effort must be made to reduce both the occurrence and the impact of mental health and wellbeing issues within its workforce. Any efforts or support from state or federal governments to help improve the levels of information available to and supports for both employers and employees in this area is welcome, and St John is open to contributing to any policy discussions in this regard.

St John over the last six years has invested significantly in understanding the impact of mental health and wellbeing issues within its workforce, both paid and volunteers, and identifying evidence based approaches to tackle these issues. This process has included participating in multiple internal and external review processes and engaging with subject matter experts across Australia and internationally; engaging with internal and external stakeholders, including the St John workforce, United Voice, the Ambulance Employees Association of Western Australia, the state government and external service providers; convening an expert panel to guide St John on the implementation of recommendations arising from the various reviews—a copy of this report was provided to the panel as part of St John's written submission—and undertaking a complete overhaul of St John's approach to wellbeing support for staff.

As a result of this process, St John believes it has developed a comprehensive and industry-leading approach to the management of employee health and wellbeing. We have multiple documents available upon request in regard to the St John wellbeing and support framework, which provides a high-level overview of St John's approach to employee wellbeing and support. St John has already provided written submission reports from the expert advisory group on the work being done by St John.

While St John are proud of the work that has been done, we recognise that, particularly in the area of mental health and wellbeing, all emergency services including St John can and must do better to address the ongoing challenges in mental health and wellbeing. This philosophy of continuous improvement and commitment to wellbeing and mental health education and evidence based best practice is being built into the St John's wellbeing and support framework and in the ongoing review processes that St John has committed to.

CHAIR: Thank you. I might quickly start off and then go to Senator Urquhart. Just to the WA Police Force: I appreciate what you said, and we do have some evidence that people have actually had a good experience going through some of WA Police Force processes. But Dr Mathew Samuel today just talked about a situation that happened last week that doesn't quite fit in with your mission. It was that someone who had already taken three weeks sick leave and was privately getting support for PTSD treatment was asked to do another week with them, and, even though they had ample leave—in fact, still over 100 days, apparently—they were effectively performance managed because they'd already taken three weeks leave. I did ask whether this was a historic event, but apparently it was this week.

So, I'd just make the observation and would ask you to comment on this: throughout this inquiry we have heard sometimes incredibly glowing self-assessments of people's performance from management, but when we actually hear from the workforce there seems to be an enormous disconnect between what is said to be able to be delivered and accessed and what people actually feel that they can access and that can be delivered. So, I was just wondering whether you are aware of these problems and what you intend to do about it. It is one thing to have a good policy framework and set-up at the beginning—in fact, it's essential. But unless it's actually right through the organisation it doesn't work.

Mr Clark: Obviously I can't comment on that particular case, because I'm unaware of it. And I suppose there's no surprise that we'll put our best foot forward in these things.

CHAIR: Of course.

Mr Clark: And there are always people who have different experiences. I suppose that's where I ended up with my statements. We recognise that there's still a lot of work to do around these things. The police officers have up to 168 days of paid sick leave per year every year. It's non-cumulative. At the discretion of the Commissioner of Police, it can be extended. We do have some people who have significant amounts of time off as sick leave. Just as a general observation, I think that for anyone who is taking time off work sick there may be pressures that they believe are placed on them, whether it's peer pressure or management pressure or just organisational pressure, to get back to work as quickly as possible. I think that's a reality of life. I think that's what happens.

However, as an agency we do recognise that our health and safety area has to improve. There are a number of things—just this year our corporate board has approved a number of projects. I can run through some of those things. Surprisingly, we have never had a case management system. They've now approved for us to implement a case management system that will be in place by the end of the year and will give us greater oversight of those people who are taking sick leave and the kinds of injuries that people have, and it will be able to track and monitor that. Also, we're in the process of establishing a new illness and injury management unit, which is actually the area that Inspector Higgins will be managing from effectively this week. Our corporate board has just approved that and effectively we have a new management system which is going to be more collaborative with the individuals who are ill or injured. The idea is that rather than have people either being treated differently, depending on who their manager is, or not knowing what services are available to them or just being left out and falling through the cracks, we will have an illness and injury management unit, which will be able to engage with those people, engage with the officers and with their healthcare provider and make a more collaborative arrangement. Again, this is me putting my best foot forward. I think we will do things right and we'll do things wrong and we'll learn from that.

CHAIR: Yes, because this is the real test, isn't it? If I bumped into one of your members this evening and asked them, 'Would you feel comfortable telling your line supervisor that you believe you have a mental health issue and that you're seeking help? You'd be confident, you could do that and get help and it wouldn't be detrimental to your career into the future,' what you think they would tell me?

Mr Clark: I would say that a police officer and anyone who is working in the police service is probably a fair representation of a lot of people in society in relation to their views on mental health. I think mental health has for a long time had a stigma attached and continues to have a stigma attached. I can't honestly say that that's not reflected amongst our ordinary workforce or the managers.

CHAIR: But ultimately that's where we need to get to, isn't it?

Mr Clark: Well, I suppose our challenge—one of the harder things is for us to change society. One of the probably easier things is for us to change our workforce. I think we recognise that challenge. I don't know what the response would be. I think it would depend on who you bumped into. I couldn't say that every single person would have a positive view of that. We are trying to change the services. We are trying to be more collaborative with our workforce. Part of it is to make sure that we have proper educational facilities where we continually—not just in the first six months of someone's policing career—advise them on mental health issues, such as how to recognise them, how to deal with them, how to deal with them in their colleagues as well and what support services are available. It's how to treat mental health the same as they would someone who has broken a leg or any other physical illness or injury. They are our challenges, but I think we are a reflection of society as well.

CHAIR: Ms Roberts, could you just elaborate on effectively the no pushback claim situation you've negotiated with your insurer? Maybe you should just elaborate a little bit more.

Ms Roberts: Part of that is based on the fact that the insurer and DFES have a very clear idea about who is responsible for doing what. We don't get involved in any determination of liability. We leave that as a matter for the insurer.

Senator O'NEILL: Who is the insurer?

Ms Roberts: RiskCover is the our insurer. Through the relationship that we have with Lindsay and all of her team in the workers' compensation and injury management branch and their counterparts at a RiskCover, it has been a process whereby we're educating the RiskCover personnel about the occupational prevalence of exposure to trauma and what that might mean. We are also working with them around the claims process. On most occasions now, there is not a requirement for a factual investigation. We had found previously that the factual investigations were actually quite distressing for the claimant, as they were having to often relive or justify their injury.

Senator O'NEILL: Which might not be a single incident. It could be the cumulative impact.

Ms Roberts: It could be the cumulative impact. We had a conversation while we're waiting to come in that often the worker may present with a physical injury and then will develop a mental health issue as a secondary issue. It has really come about through a lot of working very closely, trust and sharing of information as it relates to the workers' issues. We do have a case management system; we've had a case management approach that works across both our wellness function, as well as our workers' compensation and injury management function. We do a lot of education with line managers and supervisors about managing and supporting sick and injured workers to have a favourable return to work. It hasn't been something that's happened overnight, but it has certainly been quite a deliberate campaign that has unfolded over about two or three years to get us to the place where we are now.

CHAIR: Maybe this is in your submission, but I don't recall seeing that detail: have you reduced all of that to a policy position that you could provide to the committee? We're very interested in that and whether or not you have now done any analysis of the positive benefit of taking such an approach.

Ms Roberts: For your first question, it's not a policy position in regard to the relationship with the insurer. We do have a policy around the management of sick and injured workers. We can certainly share that with you, and that outlines our approach.

CHAIR: Does the insurer actually have a policy approach or anything in writing about how they deal with PTSD that they could share with us?

Mrs McCabe: We can certainly ask them. They don't to my knowledge, but we can certainly ask them.

CHAIR: They must be guided by something when these claims come across their desk.

Mrs McCabe: When they're looking at a claim liability, they are following the Workers' Compensation and Injury Management Act and they are looking to see if the injury arose out of or in the course of the employment. Part of our role is to get them as much information at the start as we can to help them make that decision quickly so that it doesn't impact the injured worker, whose is going through treatment, sometimes hospitalised or sometimes in crisis. The information that we provide to them to allow them to make that decision relates to the types of incidents that they've been subject to, whether that be a fatality or a very traumatic road crash rescue. We can get that information—

CHAIR: So you actually provide the evidence for the claim, rather than the employee trying to find that?

Mrs McCabe: Yes.

Ms Roberts: We don't make the worker have to justify it, in terms of providing the evidence for it. That has certainly been key to facilitating the acceptance of liability. We have occasionally had some issues where it's very old records that we might have to spend a bit of time trying to retrieve on behalf of the claimant. But our business is to make sure that the worker gets all the support that they're entitled to as quickly as possible.

CHAIR: We would appreciate any documentation you can provide in respect to that.

Senator URQUHART: It sounds like a fabulous model. I presume that it will have some trust and cultural benefits between the worker and the employee.

Ms Roberts: Yes, I think one of my colleagues just pointed out that one of the key changes we made in terms of our approach to managing our sick and injured workers was to recruit a team of allied health professionals. They are injury management consultants, not case managers.

Senator URQUHART: So they understand. It makes a lot of difference.

Ms Roberts: They have a deep understanding of the experiences that the workers are going through. I would say that probably the best investment that the organization has made is to recruit a team of very talented and committed allied health professionals.

Senator URQUHART: Is it something that you share with the other departments in other areas?

Ms Roberts: We've been doing a fair bit of collaboration with our colleagues at corrective services, who have recently gone away from a case management approach to an injury management approach. They are certainly moving down that path. The crew do meet regularly with our colleagues and the other first responders. There's an informal network that gets together. There's also a formalised network through our peak body, AFAC. I'm not sure whether you've heard of that in your travels around the around the country.

CHAIR: We may well have. We are flooded with acronyms.

Ms Roberts: It is the Australasian Fire and Emergency Service Authorities Council, which is kind of like the peak body for all of the fire, state emergency services and rural land management agencies. They have a mental health and wellbeing network. That's a very vibrant network of about 30 practitioners. They collaborate on national mental health initiatives, and there's a lot of information sharing.

CHAIR: We must say that the fire services in Canada actually have provided evidence to this inquiry. Some of the work they are doing is quite remarkable, to be honest.

Ms Roberts: We have a working relationship with the Edmonton fire service around some of their practices as well. We're in touch with them about a holistic health and wellbeing model, which will include a behavioural and mental health component as well.

Senator URQUHART: It always surprises me how other organisations and other areas don't pick up a really good model and run with it, because it just seems to make sense. I've got a lot of questions. I'm not sure whether I'm going to get through them in time, but I'm going to start with St John and work my way through. Earlier today we had the Sirens of Silence. In their submission, they identified issues around breaches of confidentiality, bullying and intimidation, and performance managing out mentally ill staff. What I'd like to do is to give you some opportunities to respond. I don't know whether you were listening to their evidence, but there were certainly some serious allegations. I'm offering you the opportunity to respond.

Mrs Lawrence: We are not aware of those specific incidents that you're referring to, so we're unable to comment without specific details.

Senator URQUHART: Have you read the submission from Sirens of Silence?

Mrs Lawrence: Yes, I have.

Senator URQUHART: So you haven't got in touch with them to investigate what those allegations are?

Mrs Lawrence: No.

Senator URQUHART: Is that something that you would do?

Ms Jackson: The organisation has been in contact with a number of people who have provided support and has been working for a number of years, in fact, in relation to a couple of situations. We continue to do so and will continue to be willing to do so.

Senator URQUHART: The other one that I wanted to raise, in terms of the evidence that was given from Sirens of Silence, is that they also argued that while reviews have made a number of important reforms many are cosmetic in nature and the core of St John organisation hasn't changed. Again, I'm offering you the opportunity to respond to the evidence that we heard earlier.

Ms Jackson: The journey we've been on has been for the last four years, culminating in the last 12 months where we accepted 26 of the 27 recommendations as a result of the culmination of the three reviews. The organisation's been very transparent—developed an operational plan and shared that with the organisation. I've brought along a USB, because while I understand that we sent you the report there were lots of links to the evidence and really pragmatic and practical information that demonstrates that we've got real action happening, and I think it's really important that I pass it on to you.

Senator URQUHART: Yes.

Ms Jackson: And we have been. The report was released this year, and the final report does demonstrate the real work that's being done and the real action at the ground level.

Senator URQUHART: Recommendation 24 in that report, to incorporate agreed key performance indicators relating to psychological risk and care of the workforce within your contract with the state government, was not agreed. I think you said that you already have legal obligations to your staff—and I guess that's correct; nobody

would argue that you don't have legal obligations to your staff. But the contract between your organisation and the state government is unique across the country, because you are the only ambulance service that's not effectively part of a state government. You are contracted to a state government.

Ms Jackson: And the Northern Territory as well.

Senator URQUHART: Sorry, the Northern Territory as well; that's right. But your staff are performing a public service; I don't think anyone would argue that that's not the case. Such a change to the contract could come with obligations placed both on St John and the state government. So can you outline why you think such a step is not necessary and, given the public concerns, how the people of Western Australia can have confidence in your care and support for your staff as you bring up the centenary of your service?

Ms Jackson: I think that is probably a question that I could take on notice. I would add, though, that the contract negotiation obviously is between St John and the health department, and that would be subject to those negotiations.

Senator URQUHART: Right. So when do those negotiations finalise?

Ms Jackson: We've just finalised a two-year contract.

Senator URQUHART: And it doesn't include that section?

Ms Jackson: Correct; that's right.

Senator URQUHART: Also on the contract, I understand that funding is not linked to service outcomes more generally. Is that correct?

Ms Jackson: The funding is provided by level of service, by level of response for the WA community.

Senator URQUHART: What incentives, beyond the fundamental desire to do your best for the community, are embedded in the contract? And are there any areas for improvement within the contract?

Ms Jackson: I would have to take that on notice.

Senator URQUHART: What's in the contract? Is the committee privy to what that contractual arrangement is?

Ms Jackson: This committee?

Senator URQUHART: Yes.

Ms Jackson: No, I haven't provided a copy of the contract.

Senator URQUHART: No, but are you able to?

Ms Jackson: I'm sure I can, yes.

Senator URQUHART: Okay, that would be good if you could provide that.

Ms Jackson: Yes, I'll take that on notice also.

Senator URQUHART: Yes, if you could provide that to the secretariat, that would be all. I might throw a few questions open to all on the panel, and whoever gets first go can—

Senator O'NEILL: Whoever wants to be the first responder!

Senator URQUHART: Exactly. My next question was raised in United Voice's submission, but I think it's relevant to all organisations. They seek formal recognition that frontline emergency service workers can suffer adverse final effects from trauma experienced at work. Is that formal recognition practical and possible, and if not why not? Who wants to kick off?

Mrs Lawrence: How would you define formal recognition? What does that mean?

Senator URQUHART: I don't know what it means. What does it mean for you?

Mrs Lawrence: Acceptance of a worker's comp claim, if they put in a worker's comp claim.

Senator URQUHART: Is that the only thing? What if the worker's comp claim's denied—you're saying then that the person doesn't have an issue?

Mrs Lawrence: I think it's probably relevant to look at the evidence behind declined claims. For us, we've had 41 psychological claims since 1 August 2015. Only eight of those claims were declined, and four of them ended with settlement.

Senator URQUHART: Sorry, four of the eight?

Mrs Lawrence: Yes, four of the eight finished with settlement, and out of those four that were left only two of those staff were operational staff. The other staff were admin and support staff. So if you're looking at it within

the context of this inquiry, it would be relevant to the operational staff. So, ultimately, out of 41 claims since 2015, only two have been declined anyway. And I think the other scenario behind that is having a really robust early intervention and prevention program in place. Our staff receive two hours of wellbeing and mental health education every year, so we're building resilience and capacity in our staff. Our new recruit ambulance officers go through resiliency training that we are going to be putting through an evaluation with Curtin university. Then, for staff that do require early intervention, we have a robust network of psychologists experienced in working with trauma that those people can link in with.

CHAIR: Can I just come back to the eight claims that were denied and then four were settled? Why were those four denied in the first instance, if they were then settled?

Mrs Lawrence: I can't answer that. I'd have to take that on notice.

Senator O'NEILL: Who is your insurer?

Mrs Lawrence: Allianz.

Senator O'NEILL: And who is the insurer for the police?

Mr Clark: We're self-funded. That question is about presumptive illnesses. I think there are a couple of things. As I said in my opening statement, we accept that traumatic incidents at work can affect people's mental health. I think as an agency we accept that. If we had a normal workers compensation—

Senator URQUHART: Whether or not there's a workers comp claim, you accept that?

Mr Clark: Absolutely. We don't have workers comp claims. Because we pay for all work and non-work related, for us it actually, in a practical sense, makes no difference for the officer—or should make no difference.

Senator URQUHART: I think you said that you actually support your officers going to their own GP for psychological—

Mr Clark: Yes. The issue is about the payment for services and the provision of those services. We believe that it's right that officers should be able to go to whoever they wish to treat them. We will pay for those services and that treatment, as long as it's a recognised treatment and it's a scheduled treatment. Whether someone was suffering from a mental health illness which, if you could pinpoint it, was related to something external to work or whether it was at work, it makes no difference for us. We would pay that anyway. I suppose it makes it easier for us as an agency.

Senator O'NEILL: So we get a bit of a comparison, how many claims have you had and what's been denied?

Mr Clark: One of the things I said is that we didn't have a case management system. Our claims management unit deals with thousands of claims a year. They can be anything from pharmaceutical claims for people to—the only limit we have is that you must make a $200 claim in one go in a three-year period. As soon as you've got over $200 worth of pharmaceutical or doctor's costs, you can put your claim in.

Senator O'NEILL: How many mental health ones are there amongst that?

Mr Clark: I'm unsure of that.

Senator O'NEILL: Please take that on notice and the breakdown. We're talking a lot about PTSD, but I think evidence we've received today has really indicated that you might not present with PTSD; it could be anger management or breakdown of family relationship or any other form of mental distress.

Mr Clark: I think that's where we have that difficulty in providing specific numbers. A lot of the claims that we have might be multifaceted. I will give you an example. There might be an officer who has what appears to be a back injury and severe pain which is debilitating. We've had people dealt with as a clinical matter, as a physical issue. We've also had those same people, where there has been no physical problem found, referred to cognitive behavioural therapy. One might say that it might have been a psychological issue. We can have things that manifest themselves as physical but they may be mental. Part of the problem is actually pinpointing what might be PTSD or a psychiatric issue. Again I come back to the fact that, because they are multifaceted, we believe that the best way for officers to deal with those issues is for them to get the medical advice that they deem is suitable for them, and then we'll pay for it.

CHAIR: St John Ambulance, I just want to go back to your claims. Over that same period of time, how many suicides have you had with your employees or past employees?

Ms Jackson: Since 2015?

CHAIR: I think you said 2015.

Ms Jackson: I'd have to take that on notice in terms of the actual number.

CHAIR: Is it true—and I think it might be in your own evidence—that you have four times the average rate of suicides in your place? What do you have?

Ms Jackson: Over the last 10 years we have had five suicides that we are aware of, of people that have some connection with St John.

CHAIR: I don't have the evidence, but I think there's contrary evidence to that. You're pretty sure on that?

Ms Jackson: Yes. They're the numbers that I'm aware of.

CHAIR: Had any of them made claims for mental health injury?

Ms Jackson: From memory, one of them had made a claim.

CHAIR: Was that claim rejected?

Ms Jackson: I'd have to go back and have a look at that particular one.

CHAIR: If you could. I might find where some counter-information was provided to us, and I might put some questions on notice in respect of that.

Senator URQUHART: We've heard from the police, and I'm interested to hear from St John and the fire department in relation to workers comp—I think the fire department has covered off on it quite a bit. The nature of workers compensation in the Australian system, even though it's jurisdictional based in most instances, is that it's a combative system. I worked as a union official for 25 years representing workers, and I know the combative nature and the aggressive nature of insurers—knocking back claims and all that sort of stuff. What possible improvements do the organisations see to the current workers comp system—we heard from the fire department that they've got a model that seems to be non-combative—to ensure that staff have earlier access to medical support, are not re-traumatised and can ultimately either return to work or retire in a positive way, for both parties?

Throughout this inquiry we've heard the concern about people putting in workers comp claims and the fear for their future employment and the risks that are associated with that. The fact that they don't want to because they should be able to cope is the general view, and I think you touched on that earlier. How do you see—apart from the process that you've put in place to provide that, which sounds fantastic to me—where the onus is on the insurer, more than anything, to say, 'We've got all the evidence and we're going to knock it back,' rather than on the worker having to search for all that information? Maybe I can start with St John. How do you think, given the examples that we've heard, you could increase the non-combative nature of workers compensation for your employees, and make it easier and more acceptable for them to say, 'Hey, I've got an issue and I'd like some help'?

Mrs Lawrence: The difference between us and the government agencies is the fact that we're within a commercial insurance system. We have to navigate that system and, as you've said—

Senator URQUHART: Is that cost? What is it?

Mrs Lawrence: It's because we're a non-government organisation, so our insurance process is different to what it is for government. They're internally funded for their insurance, and we seek our insurance externally.

Senator URQUHART: So risk cover is backed by the state government? Is that how it works?

Ms Roberts: Yes, it is. We are still required to pay our premiums based on our performance. The work that we've done in terms of the relationship between us and the insurer and the relationship between the injury management consultants and the injured worker has certainly facilitated making sure that the injured worker has ready access to financial and medical support.

I think one of the other things that's made a really big difference is that we have a very strong focus on returning to work, as soon as it's medically appropriate, in some shape or form. We have quite a structured approach to returning to work on suitable alternative duties so that the worker doesn't get disengaged from the workforce, and working with supervisors to make sure that they're staying in touch with their sick or injured worker whether they're still at home or in return-to-work at another host work location. Our most recent performance is a significant reduction in lost-time injuries, because of our ability to be able to accommodate workers to return to work in some sort of capacity as soon as it's medically appropriate.

Senator URQUHART: St John is a different beast, isn't it, because of the nature of how it's funded? You have a contract with the government for a set amount of money for a period of time, and you have to work within that. Is that correct?

Ms Jackson: That's right.

Senator URQUHART: So the difficulty then is any costs associated with a workers comp claim or any other costs are then added on top of that, and you've got to find that out of somewhere. Is that how it works?

Ms Jackson: We negotiate our premiums on an annual or two-yearly basis.

Senator URQUHART: Is that in line with your contracts to the—

Ms Jackson: No, it's not.

Senator URQUHART: So you could be out of kilter at some stage, where you have a number of claims. That then pumps your premium up the next year, and you are in a contractual arrangement with a government that doesn't allow you to have more money, so you then have to strip that money out of somewhere else.

Ms Jackson: Obviously we have different revenue streams. We don't have revenue coming just from the service provision for ambulance services.

Senator URQUHART: No; if people get a ride in an ambulance, you charge them for that?

Ms Jackson: That's right.

Senator URQUHART: What other revenue streams are there?

Ms Jackson: We run the first aid training business, and we have other commercial arms as well.

CHAIR: Would you, as the premium holder, have a say on what claims are accepted?

Ms Jackson: No. The insurance company holds that liability. We buy the premium, clearly, or we have the premium. It's up to the insurer to make those decisions. However, as does the fire department, we work really closely with our insurer. We have put a number of systems and processes in place in St John to help us navigate what is a very difficult system sometimes for our employees.

CHAIR: It's Allianz, is it?

Ms Jackson: Allianz. So, equally, we have a system where, if there's a psychological claim—and Donna has absolute firsthand experience in this—the insurer clearly does sometimes take a little bit of time to make a determination of a claim. But we have systems in place to ensure that an individual continues to receive the appropriate therapy or treatment, whatever is determined.

Senator URQUHART: And they don't pay for that? That's covered?

Ms Jackson: Correct.

Mrs Lawrence: Often, people will access treatment prior to the claim even being submitted or processed. The insurer allows the person to continue in therapy with their original therapist—they don't need to change therapists. We've also had incidences recently where we've mitigated claims, where we've handled that process internally, and the person hasn't got to the point where they've needed to submit a workers comp claim; they've actually been able to get back to work and get back to full duties within that process.

I work fairly closely with the internal injury management adviser. She's a psychologist too, and she has a background in injury management. Us working closely together has very much an early intervention approach to helping people who are experiencing psychological symptoms. I think a reflection of that is our claims this calendar year; we've only had five psych-related workers comp claims this calendar year. That process of working collaboratively with the internal injury management consultant, helping people access the treatment that they need, giving the managers discretionary leave if appropriate and getting them into really intensive evidence-based therapy has been a really effective approach that we've taken over the last 12 months. Her and I have both been in the organisation for about 12 months, so we've been able to facilitate those changes.

I suppose the other thing that goes with that is working really closely with our external provider network of psychologists as well, and making sure they're able to provide the most appropriate treatment. If it does become a workers comp claim, we have a process called the 'motivated minds' process, which is an early intervention process where we liaise closely with the external treatment providers—whether that be psychologists or psychiatrists—to help navigate a really specific pathway for the person and make sure that they're receiving the most appropriate therapeutic intervention.

Senator URQUHART: I'm not swayed by your argument about workers comp claims coming down and your treatment being effective, because from my point of view—and I might be looking at this a bit on the other side—sometimes the reason that statistics come down is that people don't want to claim; it's too hard, it's too onerous and they're too scared. But the proof's in the pudding, I guess.

Mrs Lawrence: In saying that, I think there are other things going on in the organisation culturally to help reduce the stigma associated with those things.

Senator URQUHART: What are those things?

Mrs Lawrence: We do annual two-hour wellbeing mental health education with everybody. The wellbeing and support team also goes out on road with the paramedics every Wednesday. The purpose behind that is to have supportive mental health conversations. We go out to most regional locations annually and deliver face-to-face wellbeing education with volunteers, as well. We create a culture of shared responsibility, where we really try to promote everybody looking after everybody. So, if the person you're sitting next to in the ambulance isn't traveling very well, then, how do you help that person seek support and vice versa?

CHAIR: We have evidence from the ambulance service in Queensland about how they actually manage traumatic call outs. They can identify an event that potentially is traumatic for everyone involved and they are then taken out of the system to ensure that there's no longer any exposure and there's actually time to debrief and time to manage that. Do you have such systems in place or do you have the opportunity for people maybe to do more than one, or two or three traumatic events in one shift?

Mrs Lawrence: How we tend to manage it, and my view as a therapist, is that trauma is a very unique and individual experience. We all can experience the same traumatic event yet have different reactions to that event. We take the approach: rather than the event that they've experienced, is someone experiencing distress as a result of the event? So, we monitor distress, although we also take into consideration—

Senator O'NEILL: Is it self-reporting? What mechanism?

Mrs Lawrence: Self-reporting, management reporting and also peer reporting. So, there are three avenues for monitoring distress, and anyone can contact us when there is a designated big job. A big job might be defined as a suicide, anything involving children, traumatic injury, a cardiac arrest, a car accident or an assault, for example. We would do a follow-up with all of the crews involved in that job, including the call-taker. We've got a system where we can monitor the number of jobs that people go to, as well.

Senator URQUHART: How does that follow-up occur? Does it occur at the end of each incident or at the end of a shift? How does that process work?

Mrs Lawrence: We know that critical incident debriefing is not indicated, and it can actually be harmful, so we give 24 to 48 hours for someone to process an event. Then we are also able to check in and monitor things like appetite and sleep. And we usually do a follow-up phone call within 24 to 48 hours.

CHAIR: You must have management procedures that put these things in place?

Mrs Lawrence: Yes.

CHAIR: Are you able to provide them to the committee?

Mrs Lawrence: Sure.

Senator O'NEILL: I have a question about the people who are out of the cities in the bush. In terms of police, do they operate solo or do they have a partner with them so that they get shift time off and on.

Mr Clark: They have shift time on and off.

Senator O'NEILL: Are there any solos out there?

Mr Clark: None that I'm aware of, but we do have multifunctional policing facilities, which may have single officers at them in very remote areas. But if the question is about whether there is an expectation that officers who work in small communities and small stations find themselves effectively on call all the time—I think that is the question—I think the answer is yes. I was listening to the paramedic before we came in and I think the officers who are in those locations are known as police officers. Everyone knows where they live and no matter whether they're on or off duty someone could knock on their door and say that something is going on. In fact, I know police officers and I have spoken to them and there is that expectation. It's very difficult to get around that, because people in the community, if they need help, will automatically go to those officers' houses, whether they're on duty or not.

Senator O'NEILL: Is it the same for fire?

Ms Roberts: No, there is normally a large crew there, but I think the question is probably more pertinent to our volunteer responders, because often they're in a situation in country locations where if they don't turn out there is no turn out. So, they have a whole different level of personal connectedness and commitment—

Senator O'NEILL: And vulnerability.

Ms Roberts: as well as vulnerability—to staying on duty and being prepared to mobilise, even if perhaps they have had prior exposures and are still recovering from prior exposures.

Senator O'NEILL: What about paramedics in that instance?

Ms Jackson: We have paramedics and volunteer combination courier centres, and they form part of normal crews, so they are always with somebody else. The community paramedic role is a role that is about supporting the volunteer model, and their primary role is to support the model, as opposed to being a first responder per se. It does happen—

Senator O'NEILL: Technically and practically there can be a bit of a gap, I guess?

Ms Jackson: I guess there can be. It also depends on the individual as well, in terms of their tendency and their leaning to being a first responder rather than the supporter of the first responder.

Senator O'NEILL: So if you get lucky and get somebody who really cares about it, then they're on 24/7?

Ms Jackson: No, I think we've got some pretty fantastic community paramedics that perform a great role and recognise the value that they can add is in supporting the volunteers to do their role. We compare it to a coach—the coach doesn't go out on game day but is there in the background for them all, and that's how we look at the community paramedic role. It's safe to say that it is difficult in small towns when people know where the community paramedic lives, and we have a similar kind of situation, but it is one that we work hard around as well. There is something, too, that probably Donna can talk about, in terms of the supervision for these individuals, which is another level of support specifically for remote and also the community paramedic position which works alone.

Senator URQUHART: We did hear evidence in relation to the size of the area that, say, a community paramedic actually covers. They may not simply be in a small town; it might be hundreds of kilometres of area, and they may be in a corner over there and not able to be there. My question would be: is that a sustainable model for the community but also for your staff?

Ms Jackson: I think we currently have 26 community paramedics across the state, and we absolutely believe that the number should increase. So we are and we will be in negotiations in two years time, and we've talked about the number being closer to a hundred.

Senator URQUHART: So this is all linked to funding?

Ms Jackson: Yes.

Senator O'NEILL: So three times, you're talking about?

Ms Jackson: Absolutely.

Senator O'NEILL: Would it be three people per site, or are you going to shrink the areas and still keep them single?

Ms Jackson: Yes—shrink. That planning is obviously still to be worked out, but, in relation to what we currently have, it seems sensible. It means that we would have a community paramedic in every second town—depending on the area. As you may be aware, the north-west has a completely different look and feel to the south-west, in terms of the locations of towns.

Senator URQUHART: You've just completed the negotiations on the contract with the government. Was any of that consideration given for this contract?

Ms Jackson: Not on this occasion. I wasn't there, so I would need to double check that and take that on notice.

Senator URQUHART: Why not?

Ms Jackson: I'm not aware.

Senator URQUHART: Can you take that on notice.

Ms Jackson: I can.

Senator URQUHART: Also on notice: I guess you have designated areas and sizes and the number of paramedics across the state, particularly out in the community.

Ms Jackson: Yes.

Senator URQUHART: Are you able to send us a bit of a mud map of that?

Ms Jackson: Yes. We also have regional offices and the regional offices also support those community paramedics. A community paramedic is not a position that just links directly with Perth. Within the region, there is a complete regional office—a team of people—supporting the community paramedics as well.

Senator URQUHART: If you've got a breakdown of that, that would be really helpful.

Senator O'NEILL: And the same for the police, just to get a sense of the scale of response capacity, because these first responders tend to work together quite frequently, don't they? And if you have anything to add to that, that would be helpful as well, Ms Roberts.

Ms Jackson: The supervision that is provided, which is an extra level of supervision, is something that has been introduced as well.

Mrs Lawrence: One of the things that we recognise is that community paramedics do work in isolation. They experience dual relationships in town. How do you socialise with the people that you are supporting volunteer-wise? So one of the things that we have set up is clinical supervision, similar to what a psychologist or a social worker might have, with one of our external providers, and they can access up to 10 sessions a year where they can talk through what they might be experiencing. That can even be operational stuff, in regard to their line manager and that sort of thing. So they are able to seek that additional level of support, and that is available either by Skype or over the telephone or, if they are in Perth, they can come in and have—

Senator URQUHART: Are those 10 sessions governed by funds?

Mrs Lawrence: No, it's actually governed by the fact that they have eight weeks leave a year. For every month that they're on the job, they would get a monthly supervision. But, if I ever got a request that someone needed more, it would absolutely be approved because there's obviously a clinical need.

Ms Jackson: On top of that, there's the access to the external psychologists, which is for up to six sessions, and then permission is provided in a process where they can access more. There's no cap on our budget for that, and that's something that St John did four or five years ago to ensure that people had that access with no restrictions and no conditions, and that it was completely confidential. That's worked exceptionally well. I think, in this last financial year, there were roughly around 1,700 visits to external providers by our people.

Senator O'NEILL: There's a system there, and it has times in it, but, because of the nature of the work, something that might not appear to be a particularly traumatic experience could suddenly become one. Is there sufficient response capacity within the organisations that you're here representing if someone says, 'This isn't working today; I have to stop now'?

Mrs Lawrence: Absolutely.

Senator O'NEILL: Where is that response capacity? A lot of the evidence we've received across the country indicates that there's a dramatic and dangerous lack of response capacity for people to go, 'It's not working today; I've got to pull out now,' and we're getting reports of incredible pressure on people to continue to operate in an environment with very stretched resources.

Mrs Lawrence: I suppose there are stretched resources. But, if we were ever in a situation where someone needed to immediately go on leave, then that would be supported because their mental health is more important.

Ms Roberts: Certainly, from a fire department perspective, there's the capacity for people to take themselves off duty and then be provided with some sort of backfilling. Our experience with our volunteer workforce is they're far more likely to simply stop volunteering before they get to that stage.

Mr Clark: I suppose this comes back to one of the original questions, the question about the stigma that goes along with mental health and whether someone's willing to put their hand up. For us, in a practical sense, yes, someone can say, 'I'm not well today,' and not turn up to work. Is there pressure on people to turn up to work and continue? I think there always is, and it comes from lots of different places.

I would just add that police officers are police officers 24/7; it's not just when they've got the uniform on. However, when police officers put the uniform on, they're given significant powers over and above most other citizens. They have the power of arrests. They have the power to use force, even lethal force. So we do have a number of situations, and obviously a supervisor would be looking out for any signs—if someone is not acting correctly. A response group would always be two officers. If an officer saw their partner in any way not responding as they should, I think it would be incumbent on them to raise that issue. So I think there is an agency expectation that we would try and identify those things. There's also the self-recognition, and sometimes people don't self-diagnose. I think that's a reality as well. So we try and put those things in place.

One of the issues you raised earlier was about how we deal with the trauma if there's an incident. As I mentioned earlier, we have chaplains who would be on call and able to up turn up to significant incidents, whether it be a suicide, a significant car crash or those kinds of instances, and give general support to officers. We have a welfare unit, which every morning comes in and goes through all the logs of jobs. These are police officers who would recognise significant incidents that happened overnight

I think it was raised earlier by St John that it's not always the best thing to immediately do something with someone who has gone through a traumatic experience. Sometimes that can reinforce the trauma. So what tends to happen is there is a follow-up with the OIC to make sure they're okay: 'Have you checked in with this officer? Are they turning up to work? Do they appear okay?'

Again, I will put a caveat on it: it's not a perfect system. Mental health is unpredictable, and I think that's where we are. We try to have these things in place where we can recognise mental health issues. We try to put these things in place to give us indicators when someone might be going through a traumatic time. This includes trauma which is external to work as well. If someone were going through a divorce or particular financial problems, or anything in their life, we would try to pick up on those things, and we have a psychology unit where people may be referred to talk to the psychologists. Again, that is a double-edged sword. I have to admit that when someone doesn't appear to be functioning well and is then sent to a psychologist we might be doing it for two reasons. It is to attempt to help and support the officer but also to protect the public and agency from any adverse effects of someone who's not functioning correctly, given that they have significant powers. And accoutrements that can be used are force options. Sometimes that is seen in a negative sense. Officers can feel that they're under scrutiny, I think. So what we have to try and do is find a way forward that is supportive but also removes problems from the workplace, or from frontline policing where it's appropriate.

Senator URQUHART: I understand that there are bi-monthly meetings with the Mental Health Commission and all three organisations are involved; is that correct?

Mrs Lawrence: And corrective services.

Senator URQUHART: Okay.

Ms Smith: And the Department of Biodiversity, Conservation and Attractions.

Senator URQUHART: What are some of the successes that have come out of these meetings for your staff and the organisations as a whole? Are there any that are identifiable, or is it just a talkfest?

Mr Clark: I don't go to those. Unfortunately, a colleague who is sick today is the person that goes to those. What I would say is that joint learning and joint experiences are not just a talkfest, I'm sure, but being able to talk about it and understand. Given that dealing with mental health is a very difficult issue—and if anyone's got the absolute answer I wish they could give it to us—I think everyone's learning from each other. Being able to tap into an organisation like the Mental Health Commission, and professionals around that, is clearly going to be a positive. As to whether it gives the absolute answers, I would say no. It's more a collaboration.

Ms Smith: I would say, as a person who attends that with the Mental Health Commission, we've only been meeting relatively recently. We've certainly exchanged information on how all of us respond to critical incidents, and we have a matrix of that sort of thing. We also are at the stage where we're developing links and very formative ways of working collaboratively in training, and resilience in early intervention areas as well. For example, whenever the Department of Fire and Emergency Services do training in a regional area, we always open it up to all the emergency services and hospital staff in those areas.

Senator URQUHART: Do you get those people coming along?

Ms Smith: Generally, yes. And we have also had a really recent incident that was a combined services approach. It was actually St John that went and did the debriefing, and all the emergency services were invited to attend that information and check-in session. So I suppose we're in those very early, formative stages of how we work better together in training and response areas.

Senator URQUHART: Are the agendas and minutes of those meetings public?

Ms Smith: I would think not, but we could probably get those.

Senator URQUHART: It might be useful to see how that collaboration works and what sorts of things are discussed.

Senator O'NEILL: I don't know if this happens, but you have to be pretty physically fit to do the job, and clearly you have to be mentally fit to do these jobs. Is there an annual or biennial test to ascertain people's physical and mental health and wellbeing on the way through? Does that happen?

Mr Clark: Up till recently, we had a deployment readiness test which was a simulation of a number of things: jumping, running, taking down an offender and things like that. That's recently been discontinued, mainly because, as an agency, we were getting no benefit from it. It wasn't identifying any issues or problems with people. We do have an expectation that police officers will keep as fit as they can, and we do everything we can. From our perspective, it's more working with the officer to keep fit. We try to show them healthy living ways. We provide gyms and work with them. If someone is genuinely falling back on that, it may well be that we get our fitness area to work more closely with that person. We certainly have a health and safety area, and they can give advice on diet and exercise. Certainly, when an officer is in training, they will go through and they'll learn how to keep themselves fit. I think an annual test is something that would be quite onerous for people to do. It certainly wouldn't be something that we would expect of them. That said, we do have critical skills training in three areas

of critical skills, which is annual. The expectation is that an officer would need to have those critical skills signed off every year. If there were any issues that were identified at that time, that would be raised with us.

Ms Roberts: From a fire perspective, no, we don't. We're in negotiations with our principal industrial body about developing a holistic model that would involve periodic medical, physical and wellbeing screening. It's still in its negotiation phases. As far as the volunteer workforce is concerned, that's very much over-the-horizon kind of thinking, given the scale—potentially 30,000 emergency services volunteers. So that's not really on the agenda at this point.

Senator O'NEILL: It's interesting, though. If you could find something effective and you implemented it, it would have an impact not only on the workplace engagement but, more broadly, on general health outcomes as well. What's the situation with St John?

Mrs Lawrence: Ours is voluntary. People have access to $500 a year as a wellness package that they can use for gym memberships, pilates, yoga and that kind of thing.

Senator O'NEILL: But there's no ongoing monitoring of people's physical or mental wellbeing?

Mrs Lawrence: No. The expert advisory group report that we provided to you actually showed that there is no evidence at the moment to support mandatory mental health screening. However, what we do encourage people to do is use the six sessions per year with an external provider that they're entitled to—not necessarily to use it if they've got a mental health issue but to use it to do a mental health check-in and build some resilience and some capacity. We're also just about to introduce an online mental health screening tool. That again will be voluntary, but people can go online and complete it.

Senator O'NEILL: Privately?

Mrs Lawrence: Yes. Then, if they have an elevated score, they'll receive a 15-minute debrief with a psychologist and then, if they're interested, linkage with one of our external providers.

Senator O'NEILL: Thank you.

CHAIR: Thank you. We would love to keep going, but things have to end eventually. Thank you for your indulgence in staying later than scheduled and for your contribution to our inquiry

Committee adjourned at 17:33