Independent Oversight Panel | August 2016

Review of St John Ambulance: Health and Wellbeing, and Workplace Culture

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Chair's Foreword

St John Ambulance plays a significant role in the delivery of health care in Western Australia. Its roles in the delivery of pre-hospital care and patient transport services are critical components within our health care system. The valuable role played by paramedics, operations staff and volunteers is widely recognised and acknowledged.

Unfortunately, in carrying out their role, the ambulance service, paramedics and volunteers are particularly vulnerable to developing posttraumatic stress disorder in the course of their working career. The risk is more than double the general population and is higher than for police officers or firefighters. Additionally, exposure to traumatic events is a specific risk factor for suicidal ideation and suicide attempt.

This issue is not unique to St John. Ambulance services (and first responder services) both nationally and internationally are struggling with issues relating to the impact of these stressors and how to effectively manage and support their workforce in dealing with these stressors.

The Panel has found that many who spoke to us of their experiences in the workplace and the stressors that they and their colleagues faced, remain emotionally scarred and I would like to thank them for sharing their experiences.

I would like to thank the St John Board Directors, Mr Tony Ahern CEO, and his Executive Team for their support and information provided to the Panel during the process.

To move forward it will be important that all parties cooperate to address the issues related to organisational culture and health and well-being. Decisions will need to be made, and further changes to policy, procedures and practice will need to be put into place. The health and well-being of all employees and volunteers is too important to not to continue to address these sensitive issues.

I would like to acknowledge and thank Panel members Professor Alexander MacFarlane, and the Hon Ian Taylor for their considerable expertise and diligence to the review process. I would also like to acknowledge and thank the Panel's support team of Donelle Rivett and Linda Adnyana who effectively managed the administration requirements of the Panel, as well as assisting with research and the preparation of this Report.

DR NEALE FONG
Chairman
Independent Oversight Panel

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Executive Summary

As a result of concerns raised by the paramedics and the public on paramedic health and well-being, and a reported number of paramedic and volunteer deaths from suicide, St John Ambulance Australia (WA) Ltd (St John) commissioned an independent review of their workplace culture and well-being of their staff and volunteers. The Independent Oversight Panel (Panel) was tasked with examining the workplace culture and the well-being and support programs provided to staff and volunteers, identifying issues arising from consultation and other external St John commissioned reviews, and providing recommendations for improvement, including factors surrounding the recent deaths of paramedics.

The outcomes of this report provide St John with a unique opportunity to address cultural and operational concerns raised through the consultation process, and to improve and enhance the health and wellbeing support services.

Ambulance services (and in general first responder services) both nationally and internationally are in a significant state of flux. Almost all Australian ambulance services have been under review for issues related to service delivery, and/or cultural and organisational aspects in the last ten years. A number of key features arising from these reviews have identified that ambulance services:

- Have a high public expectation for delivery of safe and effective systems of emergency pre-hospital care;
- are facing pressures linked to growth in demand for services and the associated pressure to deliver timely responses to this demand growth;
- are facing increased pressures to manage cost of service provision;
- are having to improve clinical governance and clinical review process; and
- are being required to be increasingly innovative in their responses to the these demands.

It is within the context, that St John management, paramedics, operations staff and volunteers operate in Western Australia.

One of the significant aspects of the review was to provide a comprehensive literature review describing the higher risks and psychological disorders associated with emergency service personnel. Specifically, the Panel found that:

- Evidence from a variety of research indicates that the cumulative impact of trauma exposure increases the risk of PTSD and other adverse health outcomes. Thus, it is important to consider lifetime trauma history, accumulated in the course of an emergency service career and the risk of suicide.
- Evidence indicates that emergency service personnel have a significant risk of developing posttraumatic stress disorder in the course of their working career. The risk is more than double the general population and is higher than for police officers or firefighters.

- Exposure to traumatic events is a specific risk factor for suicidal ideation and suicide attempt.
- There is a relationship between physical and psychological morbidity.
- The adverse health outcomes of an ambulance officer are related to a matrix of factors, including the cumulative traumatic stress involved in the role, organisational factors and individual risk factors.
- A percentage of individuals exposed to traumatic events have a progressive development of symptoms with the passage of time which supports the need for early identification of symptoms in emergency service workers because it highlights significant levels of current morbidity and the future risk to the workforce.
- Organisational and workplace factors including social aspects of the work environment are predictors of PTSD, burnout and fatigue. These include lack of social support from colleagues, lack of social support from supervisors and poor communication.
- There appears to be a link between length of service and less recovery time between incidents and higher levels of burnout and posttraumatic stress symptoms. Moreover, experienced staff are expected or feel they are expected to cope better and as a consequence were more reluctant to express their distress. It highlighted that managerial staff may have tended to be less alert to the needs of these experienced staff and the early warning signs of difficulties in this group.
- The mental health consequences of bullying and harassment have been well documented in a variety of occupations.
- People with PTSD, mood disorders and substance abuse disorders have been shown to have an increased rate of suicide, with approximately 90% of people who attempt suicide having a psychiatric disorder, such as depression, and posttraumatic stress disorder.
- Completed suicide is generally preceded by some form of suicidal expression such as ideation, plans or attempts. Thus, identifying and focusing on suicidal thoughts and behaviours provides effective opportunities to prevent suicide deaths.
- There is a positive relationship between cumulative trauma exposure and likelihood of suicidality.

In summary, the Panel has found that the cumulative burden of trauma exposure is an important risk factor that could be better anticipated and managed by St John in relation to the predictable rates of psychological injury and the related risk of suicide in ambulance officers.

The Panel identified a number of themes emerging from two reviews (Chief Psychiatrist of Western Australia and the *Phoenix Australia Report*, Centre for Posttraumatic Mental Health, University of Melbourne Reviews) along with the written submissions and private hearings process. These have been categorised as:

- Nature of Ambulance Service Work in the Field (including the State Operations Centre)
- Workforce Wellness
- Organisational Culture
- Operational Management
- Policy and Procedures
- Issues Specific to Country Ambulance Services
- The Wellbeing and Support Model
- Employment Conditions

The Panel found that employees in emergency service settings operate in unique contexts facing challenges not experienced by other workers. The *Phoenix Australia Report* articulated this well stating that "*St John employees are exposed to a range of psychological risks during the normal course of their work including shift work, potentially traumatic events, working in a high demand low control environment, and for some, working in a geographically isolated area*".

There can be no doubt that the work frontline ambulance service roles, including paramedics, communications officers and volunteers, is unpredictable, stressful and challenging with many complex factors contributing to this environment.

Submissions received and hearings undertaken by the Panel were generally silent on the connection between the nature of the role as a first-responder and mental health problems. However, this was not surprising, as previous studies have shown that frontline workers accept these exposures as part of their work but tend to underestimate the associated risk and effects. What the workforce do not anticipate is the impact of organisational stresses which they contend can exacerbate unnecessarily the consequences of the traumatic stresses in the workplace.

Participants consulted were generally positive about their employment conditions in terms of pay, roster structure and leave allocations. Some participants, however, noted long shift lengths directly contributed to fatigue, and the lack of flexibility in rostering and the taking of leave being not conducive to effective self-management of fatigue. Consultations also revealed that organisational and workplace factors relating to management style and decision-making processes, perceived lack of communication and the existence of bullying as being major contributors to feelings of stress at work.

It was apparent that individuals who choose to work in frontline emergency service roles (paramedics, volunteers and communications officers) tend to have high levels of commitment to their first-responder roles and for serving the community. This was an overwhelming sense the Panel gained through its consultations. It seems appropriate then, that the community and the employer owe these first-responders a particular duty of care if they are injured or become unwell, whether physically or psychologically.

Individuals expressed sincere loyalty to 'the Saint' (SJA) and to each other, and were highly committed and vested in the success of the organisation and its continued

service to the community. The Panel did not at any time get a sense those at risk of psychological injury were a small group of staff who need special consideration and posed a particular challenge to management. Individuals were honest and balanced in their accounts of their treatment and of their own personal actions or reactions. Some showed emotional scarring being deeply affected by the deaths of their colleagues, the mental health struggles of other colleagues and the trauma of their role as first responders.

Whilst acknowledging the relatively small sample size involved in consultations, the Panel has reached the conclusion that there are some elements of the culture of St John displaying aspects which could be described as dysfunctional, a strong theme that emerged throughout the consultations.

Some of the participants who approached the Panel expressed a lack of trust in management and a perception of a lack of impartiality in management decisions and actions. In the absence of a whole of workforce culture or staff satisfaction survey it is not possible to comment on how widespread these issues are, however, the cases discussed with the Panel were significant enough to warrant concern.

Examples provided by participants in the course of Panel consultations raise concerns as to the organisational culture. The examples given indicate that bullying and other inappropriate behaviours are occurring at manager to subordinate and peer to peer levels. Evidence in the *Phoenix Australia Report* identified that subordinate to manager bullying is also present in the organisation.

Much consideration has been given to the recommendations to ensure they are specific, achievable and importantly, impactful. It is recommended that St John establish a robust approach to the consideration and action planning to address recommendations made by the Panel, *Chief Psychiatrist* and *Phoenix Australia Reviews*.

Some form of ongoing oversight involving internal, external and workforce representation should be considered with periodic reports provided to the Board. Further, it is recommended a formal review of progress toward addressing the issue of psychological risk and care for the St John workforce is undertaken in twelve months' time, reporting to the Board and the Director General and/or Minister for Health.

Findings and Recommendations

Nature of Ambulance Service Work

Finding 1
It is the view of the Panel that there appears to be a degree of reluctance by St John to accept the magnitude of the risk presented by the day to day work of paramedics, communications and transport officers. The Panel's view is that this is due to a failure to thoroughly consult contemporary evidence. Consequently, there appears to be a lack of appreciation for the extra care needed to ensure this psychological risk is managed adequately.

Finding 2
It is the view of the Panel that because of the increased psychological risk to ambulance service workers, St John has a duty of care to provide a comprehensive and integrated model of wellbeing support ranging from identification/screening, early intervention, effective triage and management of care, and adequate access to immediate and ongoing specialist care.

Finding 3
It is the view of the Panel that improved workforce planning and support for career transition pathways will improve options for staff who can no longer work in frontline roles but who still have value to add to the organisation.

Finding 4
It is the view of the Panel that in the interest of moving quickly to allay concerns and minimise damage, St John's response to the issues to date surrounding the alleged suicides in the workforce have been overly and unnecessarily defensive and reactive. St John now has an opportunity to develop a long term strategic response.

Recommendation 1: Formalise understanding of the unique psychological needs of the ambulance workforce

It is recommended St John engage a qualified mental health professional with expertise in emergency service workforces to assist the organisation to develop a formal position on the unique needs of the ambulance workforce and ongoing needs for mental health care.

Integral to this is an up to date expert and comprehensive knowledge of the relevant literature.

Recommendation 2: St John Workforce Mental Health Study

It is recommended St John consider conducting a study into the mental health of its workforce and the risk factors for disorder, including suicidality. There would be merit in establishing this as a longitudinal study which would feed into continuous improvement of the wellbeing and support model and would allow St John to regularly measure the effectiveness of its model.

Consideration could be given to expanding this to include all emergency service agencies in Western Australia which would give this State a leadership position in the country.

Recommendation 3: Career Planning and Transition

It is recommended St John work collaboratively with the workforce and workforce representatives to develop more effective career transition pathways underpinned by a strategic workforce plan and actuarial model of the workforce. Consideration should be given to options such as dual qualifications, and creation of new workforce roles including roles in Wellbeing and Support.

Wellbeing and Support Model

Finding 5

It is the view of the Panel that despite an increase in resources in the provision of wellbeing and support, St John's current approach is inadequate. It is not sufficiently evidence based and is over-reliant on a self-referral approach.

Finding 6

It is the view of the Panel that screening of the frontline workforce should occur prior to, and periodically throughout employment. This needs to be undertaken in a transparent and integrated framework of identification, follow up and treatment as required, and be mindful of the law relating to privacy and employment conditions.

Finding 7

It is the view of the Panel that implementation of a tracking system to monitor staff exposure to trauma is critical. Again, this must be within an integrated framework referred to in Finding 6.

Finding 8

It is the view of the Panel that downtime immediately following a traumatic call should be provided, if requested, as it forms a critical element to effective self-management of trauma exposure. St John advises this is current practice however the Panel heard examples from Participants of situations where it did not occur.

Finding 9

It is the view of the Panel that in addition to the continued whole of workforce approach to education, St John should reinstate the dedicated Peer Support network.

Finding 10

It is the view of the Panel that St John need to ensure that appropriately qualified mental health professionals, namely clinical psychologists with expertise in the effects of traumatic stress are employed in the Wellbeing and Support team in order to direct the provision of an adequate wellbeing service. Anything less is not adequate.

Finding 11

It is the view of the Panel that coordination and collaboration in the provision of wellbeing support with the Department of Fire and Emergency Services and WA Police should be formalised either through a separate entity, or at least through a formalised platform as recommended in the 2012 Toll of Trauma report.

Finding 12

It is the view of the Panel that the sites affected by the suicides in the St John workplace need special attention to assist with healing and overcoming the trauma they have experienced.

Finding 13

It is the view of the Panel that consideration should be given to the need for, and an appropriate model of, support for ex-frontline workers of St John.

Recommendation 4: Integrated Wellbeing and Support Strategy

It is recommended St John develop and implement evidence based integrated wellbeing and support strategy.

Phoenix recommendation 6, 7 and 8 (Wellbeing and Support) are supported:

6. Employ qualified and experienced mental health practitioner/s on the Wellbeing and Support team.
7. Modify the content of mental health literacy and psychological first aid to be consistent with best practice approaches to these programs. Implement these

programs across the organisation to ensure that staff are supported and their wellbeing monitored in an ongoing way, but particularly after a potentially traumatic event.

8. Formalise the existing avenues of support into a wellbeing and support model that provides St John staff with clear guidance on the different levels of support that are available to them, based on preference and need. Ideally, a dedicated peer support team would be a part of the wellbeing and support model.

This integrated strategy should take into account the literature review findings in Recommendation 1, findings of the Chief Psychiatrist Report, Phoenix Report, and Independent Oversight Panel Report, and incorporate an explicit employee engagement strategy to ensure staff input into the model.

It should incorporate requirements for screening and a tracking system.

Recommendation 5: Screening

Phoenix recommendation 11 (alternative approaches) is supported:

Implement regular mental health screening of staff wellbeing combined with tailored self-care information.

11.1 On an annual basis, staff undertake an anonymous online mental health screen that provides feedback on wellbeing, guidance on self-care, and recommendation for appropriate level of support and professional care, where required; and

11.2 On a two-yearly basis, staff have a face-to-face or telephone mental health screen with a mental health practitioner. On the basis of the results, the mental health practitioner would provide feedback to the employee and make recommendations for ongoing self-care and/or mental health treatment if required.

Recommendation 6: Ownership of wellbeing and support model

Chief Psychiatrist recommendation 1 is supported:

It is recommended St John work in close partnership with staff, volunteers and their families, to review their wellbeing and support services to increase 'ownership' and address the challenges in providing such services.

Recommendation 7: Workplace Healing

Chief Psychiatrist recommendation 2 is supported:

It is recommended that St John broaden its response to the impact of suicide and other forms of traumatic death amongst its staff and volunteers by providing proactive, ongoing support focussed on the work group, which recognises and builds upon the group's coping strategies.

Recommendation 8: State-wide Coordination

It is recommended the WA State Government give consideration to the formalised coordination of the provision of wellbeing support for emergency service personnel.

Recommendation 9: Tracking System

It is recommended a system is implemented in St John which tracks staff exposure to trauma and that this is used to flag individuals in need of proactive follow up by the Wellbeing and Support team.

Recommendation 10: Ongoing monitoring and evaluation

It is recommended St John establish an ongoing expert panel to oversee the implementation and operation of its wellbeing and support model.

Operational Management, Policies and Procedures

Finding 14

It is the view of the Panel that training for staff moving from frontline service into management roles must be strengthened. Training for all management positions should be provided on an ongoing basis. This training should focus on the application of policies and procedures as well as appropriate management behaviours.

Finding 15

It is the view of the Panel that a revised leadership framework appropriate for St John's professional organisation is required. The Panel's view is that the tension created by an organisation in transition is contributing to issues with management and leadership capability.

Finding 16

It is the view of the Panel that St John's performance management framework needs to be reviewed to take into account St John's transition to professional registration of paramedics, as well as the connection between poor mental health and poor performance.

Recommendation 11: Training, Education and Support

Phoenix Report recommendation 3 and 4 (Training, Education and Support) are supported:

3. Engage with mental health professionals (either internal or external) with relevant experience to provide regular and repeated workplace training for managers in how to identify signs and symptoms of stress and how to support their staff.
4. Provide initial and ongoing workplace training and mentoring for managers to ensure development and maintenance of core skill competencies for managing and supervising staff, including how to address staff issues such as bullying in a timely and appropriate manner. To ensure that skills are maintained, refresher training should be offered at least every two years.

Recommendation 12: Leadership Capability Framework

It is recommended St John give consideration to the development and implementation of a leadership capability framework appropriate to a workforce with professional registration.

Recommendation 13: Performance Management

Chief Psychiatrist recommendation 4 is supported:

5. It is recommended that St John review its Performance Management process with a view to providing clear guidance on the conditions under which:
    - The process may need to be amended or suspended;
    - Expert psychological advice should be sought
    - An independent person be appointed.

Further, it is recommended St John revise its performance management policy and procedures in light of the connection between poor mental health and poor performance; and the move towards professional registration of paramedics.

Issues Specific to the Country Ambulance Service

Finding 17

It is the view of the Panel that the current model for ambulance services in the country poses increased risk to individuals due to stressors unique to the country model. The Panel therefore believe that perpetuation of the current model for the provision of country ambulance services presents risks to the community and the State.

Finding 18

It is the view of the Panel that stringent screening of and wellbeing support for volunteer ambulance officers is critical.

Recommendation 14: Community and Country Paramedics

Phoenix recommendation 9 and 10 (Community and Country Paramedics) are supported:

9. Provide initial and ongoing workplace training for paramedics who work with volunteers to ensure development and maintenance of core skill competencies for managing and supervising volunteers. To ensure that skills are maintained, refresher training should be offered at least every two years.
10. Undertake a review of community and country paramedic processes to ensure recruitment, role clarity, training and support processes adequately address the challenges of working as a country or community paramedic.

Recommendation 15: Long Term Model for Country Ambulance Services

It is recommended St John work with the State Government through the WA Country Health Service to determine a long term solution to the provision of country ambulance services to rural and remote areas of Western Australia.

This would incorporate Chief Psychiatrist recommendation 5:
It is recommended that St John in partnership with WACHS undertake a detailed review of the ambulance service in the Northern Goldfields to determine the most effective service delivery model for this region.

Recommendation 16: Volunteer recruitment to include regional assessment

Chief Psychiatrist recommendation 6 is supported:

It is recommended that St John review its volunteer recruitment process to include an assessment by regional services (possibly including reference checks, interviews and on-the-job experience) with delegation of the final decision for acceptance to regional services.

Recommendation 17: Managing Psychological Risk in Volunteers

It is recommended more stringent psychological screening of volunteers occurs as part of the recruitment process and that explicit strategies are implemented which more effectively manage exposure to trauma in volunteers.

Organisational Culture

Finding 19

It is the view of the Panel that based on its consultations that the organisational culture of St John requires improvement. The long term success of St John's efforts to improve the psychological wellness of its workforce requires a culture that is genuinely nurtured from the top down, and at all levels. Critical to this is strong and effective employee engagement at all levels.

Finding 20

It is the view of the Panel that strategies to improve the organisational culture of St John must take into account the professionalisation of the workforce and St John's continuing transition to a professional organisation.

Recommendation 18: Organisational Culture and Employee Engagement

Phoenix recommendation 5 (Organisational culture and employee engagement) is supported:

Undertake a review of organisational culture and employee engagement, including:

5.1 Engage relevant experts to provide specific education and training to staff throughout the organisation on identifying and addressing workplace culture issues including appropriate behaviour in resolving workplace conflict, with a particular focus on bullying; and

5.2 Arrange regular staff consultations and communications to raise matters of interest and concern to staff and encourage their input and feedback; and

5.3 Arrange specific communication and consultation strategies for regional

staff to ensure region-specific issues are understood and responded to.

Chief Psychiatrist recommendation 7 is supported:

It is recommended that St John undertake the development of an Employee Engagement Strategy and Action Plan.

Recommendation 19: Staff Satisfaction Survey

It is recommended St John give consideration to implementing a system of periodic whole of workforce organisational culture/staff satisfaction survey. This would allow a systematic gathering and analysis of data, development of comprehensive action plan and measurement of success.

Recommendation 20: Conflict Management

Chief Psychiatrist recommendation 3 is supported:

It is recommended that St John investigate how to better respond to the management of conflict in the workplace, including in cases of ongoing serious conflict, using an independent skilled mediator.

Appreciation of the Legal Context

Finding 21

It is the view of the Panel that St John needs to better understand and appreciate its non-delegable responsibility for health and safety of its workforce, as it relates to mental health and psychological injury. In this context, that St John did not have active screening or tracking systems in place that are recommended by accepted clinical guidelines.

Recommendation 21: Legal Framework

It is recommended that St John undertake a comprehensive review of the legal framework as it pertains to the health and wellbeing of its workforce.

Governance, Accountability and Risk

Finding 22

It is the view of the Panel that transparency and accountability in relation to the psychological risk and care of the ambulance service workforce could be improved by inclusion of key performance indicators in the Chief Executive Officer's performance agreement and strengthened internal and external reporting.

Finding 23

It is the view of the Panel that St John has not recognised sufficiently enough the real risk of psychological injury in its workforce. Current risk management processes, in the view of the Panel, do not adequately identify and mitigate psychological risk.

Recommendation 22: Accountability in CEO Performance Agreement

Aligned with the Toll of Trauma Report recommendation 3 it is recommended the Chief Executive Officer be made responsible for the psychological health (as a result of critical incident trauma) of St John employees and volunteers, as it relates to the work environment. This obligation should be reflected in the CEO performance agreement.

Recommendation 23: Reporting to the Board

It is recommended regular and formal reporting of psychological risk and care of the workforce to the Board of St John should be implemented.

Recommendation 24: Reporting to the State

It is recommended the contract between the State and St John incorporate agreed key performance indicators relating to psychological risk and care of the workforce.

Recommendation 25: Systems and Documentation

Phoenix recommendation 1 and 2 (Systems and documentation) are supported:

1. Review Safety and Injury Support Services (SISS) documentation (e.g., risk register, OHS responsibilities) to reflect thorough consideration of psychological as well as physical risks.
2. Develop an evaluation and continuous improvement framework for managing psychological risks.

Relationship with United Voice

Finding 24

It is the view of the Panel that the current relationship between St John and United Voice WA is dysfunctional and counter-productive to achieving the best outcome for the St John workforce. Both parties play an equal role in rectifying this situation.

Recommendation 26: Collaboration between St John and United Voice WA

It is recommended St John and the workforce and workforce representatives collaborate and develop a comprehensive wellbeing and support plan which is universally agreed.

Implementation of Recommendations

Recommendation 27: Implementation Oversight

It is recommended a body be established to oversee the implementation of recommendations in this Report with a formal progress report conducted in 12 months.

1 Introduction

1.1 Background to Review

As a result of concerns raised by the paramedics and the public on paramedic health and well-being, and a reported number of paramedic and volunteer deaths from suicide, St John Ambulance Australia (WA) Ltd (St John) sought to commission an independent review of their workplace culture and well-being of their staff and volunteers by establishing an Independent Oversight Panel (Panel)(Attachment 1). The Panel was tasked with examining the workplace culture and the well-being and support programs provided to staff and volunteers, identifying issues arising from consultation and other external St John commissioned reviews, and providing recommendations for improvement, including factors surrounding the recent deaths of paramedics.

In particular, the Panel was asked to consider:

- The issues and performance around workplace well-being programs and support structures;
- Factors surrounding the past and recent deaths of paramedics including suicides and the management of personnel affected by work-related stresses and suicide;
- The management of psychological risks in the workplace;
- Workplace culture and grievance processes, including any issues of bullying and harassment; and
- Management and operation process and protocols relating to employee engagement and employment.

1.2 Structure of the Report

This Review reports on the findings of the Independent Oversight Panel.

Chapter 1 provides a brief introduction of the context of the ambulance industry and legislative environment of the current service operations. Chapter 2 moves to a more considered review of contemporary academic literature relating to stress disorders on first responders and the risks of post-traumatic stress disorder (PTSD) and suicide for this workforce in comparison with the general population. This chapter also highlights the risk of cumulative exposure to stressors and its link to PTSD. Professor Alexander McFarlane has provided his considerable expertise in this area to provide a comprehensive review of the literature.

Chapters 3 and 4 provide the Panel's consideration and assessment of the key reports commissioned by St John prior to commencement of the Panel process, both of which formed an integral source of information for the Panel. The reports and recommendations of the Chief Psychiatrist Review into *St John Ambulance Paramedic and Volunteer Suspected Suicides* and the Phoenix Australia – Centre for Posttraumatic

Mental Health *St John Ambulance Review of Workplace Mental Health Risks* are reviewed.

Chapter 5 provides a short summary and the Panel's view of a significant Parliamentary report into the support of first responders in Western Australia – *The Toll of Trauma*.

Chapter 6 outlines briefly, themes identified by the Panel emerging from public submissions received, and private and confidential hearings undertaken during the review.

Finally, Chapter 7 provides discussion of the Panel's key findings and recommendations arising from its consideration of the literature, reports and consultations.

1.3 Context and Legislative Framework

1.3.1 St John Ambulance

St John is a non-government company limited by guarantee, linked to the international Order of St John. Its motto is '*For the service of humanity*'. The organisation has a long history in Western Australia as the primary provider of ambulance services, operating since 1922, and its services cover the largest landmass in the world with a single ambulance service. St John is contracted by Department of Health (DoH) to provide ambulance services throughout the State.

St John provides two types of ambulance service, 'primary' and 'secondary'. Users generally pay, however fees are partly subsidised by DoH's funding of St John:

- Primary (emergency) transport is when injured or ill people are retrieved from community settings and taken to hospital. This is generally paid for by the individual user, although they may be able to access insurance or pensioner subsidies and discounts. St John manages the state emergency call centre for this service.
- Secondary transport (inter hospital patient transport) is when ambulances are used to transport patients between hospitals. Hospitals sending patients to another hospital will pay the fees. Within the public sector, this service has recently been opened up to other providers through a panel of providers enhancing competition in this space.

In metropolitan areas, ambulance services are provided by employed paramedics, based in depots. Ambulance services are primarily provided by two paramedics. In rural and remote areas, St John operates a paramedic/volunteer model of service provision.

1.3.2 Legislative Context

St John has a duty of care under the Occupational Safety and Health Act (1984) (OSH Act) to ensure, so far as reasonably practicable:

(a) That persons in its workplace, including both employees and volunteers, are not exposed to hazards which may affect their health: sections 19, 21 and 22 OSH Act; and
(b) That persons who are not employees (eg patients/public), are not adversely affected by the work undertaken by St John, or hazards created by St John's systems of work: section 21 OSH Act.

In the OSH Act, "hazards" mean anything that may result in injury to the person or harm to the health of the person. While neither "injury" nor "health" is defined in the OSH Act, St John have acknowledged they have their normal meanings and encompass physical and psychological injury and health.

Under the OSH Act, an organisation is required to take steps, which are reasonably practicable, to ensure that persons are not exposed to such hazards. What will be reasonably practicable in the circumstances will depend on a number of factors including the severity of the potential injury, the size of the risk of injury occurring, and whether the organisation is aware of a risk to the health of a person in its workplace (whether it is physical or psychological), it must take practicable measures to address that risk having regard to the potential circumstances.

The duties to employees and volunteers differ slightly under legalisation. As an employer, an organisation has responsibility to provide and maintain, as far as practicable, a safe working environment for employees and includes:

- providing and maintaining workplaces, plant and systems of work so that workers are not exposed to hazards;
- providing information about any hazards and risks from the work;
- providing instruction, training (including an induction) and supervision to all employees so they are able to work safely;
- consulting and co-operating with safety and health representatives (if any) and all employees about safety and health;
- where it is not practicable to avoid the presence of hazards, providing adequate personal protective clothing and equipment without any cost to workers; and
- ensuring safety and health in relation to plant and hazardous substances so workers are not exposed to hazards.

For non-employees (in St John's case this includes volunteers, patients, visitors), an organisation must ensure that the safety and health of people is not affected by the work, a hazard or the system of work. This duty, under section 21 of the OSH Act, applies where there are visitors, volunteers, work experience students or any other people at the workplace.

If an organisation breaches these duties under the OSH Act, then it may be liable for the penalties specified in the Act which differ depending on the circumstances.

In addition to the OSH Act, other relevant legislation for Western Australia is the Workers Compensation and Injury Management Act 1981 (WA). This applies to employees but not volunteers. St John have confirmed that its public liability insurance covers its volunteers in the event that they suffer an injury at work.

1.3.3 Broader Context – Ambulance Industry

There is a significant body of literature that discusses the broader context of the ambulance industry. Whilst this did not fall within the terms of reference of the Panel's review, it is important to acknowledge and understand the context within which St John operates, and in comparison with other ambulance services nationally and internationally.

In Australia, there have been a number of important reviews of ambulance services related both to operational aspects of the services and to organisational/people management within the services.

State/Service	Review/Year
Western Australia St John Ambulance	• Chief Psychiatrist Review – St John Ambulance Paramedic and Volunteer Suspected Suicides (2016) • WA Auditor General – Delivering Western Australia's Ambulance Services (2013) • St John Ambulance Inquiry – Implementation of Recommendations (2010) • Joyce Review - St John Ambulance Inquiry (2009)
New South Wales NSW Ambulance	• NSW Auditor General's Report Performance Audit: Reducing ambulance turnaround time at hospitals (2013) • Reform Plan for NSW Ambulance (2012) • Health Check: Ambulance Service of NSW (2012) • The management and operations of the Ambulance Service of NSW (2008)
Victoria Rural Ambulance Victoria	• Review of the Governance and Effectiveness of Rural Ambulance Victoria (2006)
Queensland Queensland Ambulance Service	• Queensland Ambulance Service Audit Report (2007)
Australian Capital Territory ACT Ambulance Service	• Enhancing professionalism: a blueprint for change (2015) • Lennox Report (2) – Evaluation of Progress from ACT Ambulance Service review (2014) • Lennox Report - Review of the ACT Ambulance Service: Positioning the service to meet future challenges (2010) • ACT Auditor-General's Office Performance Audit Report (2009)

Table 1 – Australian Ambulance Service Reviews 2006 - 2016

In his 2010 review of the ACT Ambulance Service, Lennox [1] identified a number of key features arising from these reviews. In particular ambulance services:

- Have a high public expectation for delivery of safe and effective systems of emergency pre-hospital care;
- are facing pressures linked to growth in demand for services and the associated pressure to deliver timely responses to this demand growth;
- are facing increased pressures to manage cost of service provision;
- are having to improve clinical governance and clinical review process; and
- are being required to be increasingly innovative in their responses to the these demands.

As part of its literature review of the history of the ambulance industry, the authors of a 2015 review of the ACT Ambulance Service summarised a number of themes that were relevant to the work within ambulance services.[2] Specifically, the following seven key themes were identified:

1. **Links to military systems** – Ambulance services have a long history of 'uniformed hierarchies' with a 'command and control logic'.
2. **Scalability** – Ambulance services are experiencing rapid changes and growth worldwide. As the reviewers note: *"… most reviews reference this, but fail to ask whether the changes in scale and nature can be accommodated within existing organisational models." (p20).*
3. **Nature of the workplace** – conflict and distrust seem to be widespread across ambulance services.
4. **Blame and Bullying** – linked to item 3, issues of blaming and bullying (alleged or actual) are a widespread feature of the ambulance industry.
5. **Professionalism** – There is considerable discussion of the growing professionalisation of the ambulance workforce, but this body of work not only neglects questions about professional development (see 3) but also does not fully resolve issues about professional status and union membership nor the closely related questions of status culture (while collar vs blue collar).[3]
6. **Adaptive Organisations** – more broadly than the ambulance service literature, excellent work exists on the attributes of peak performing and high reliability organisations with strong adaptive cultures that transcend blaming. The reviewers noted that *" while well known in the general world of organisational theory, discussion of these issues hardly appears in the relevant ambulance*

[1] Lennox G (2010). Review of ACT Ambulance Service: Positioning the service to meet future challenges (The Lennox Report). ACT Government.

[2] ACT Ambulance Service (2015). Enhancing professionalism: a blueprint for change. ACT Government. Available: http://esa.act.gov.au/wp-content/uploads/ACTAS-Enhancing-Professionalism-A-Blueprint-for-Change-Report.pdf

[3] The Panel notes that use of a mix professional/volunteer model in WA rural areas for the delivery of ambulance services, also raises the issue of management of relationships between professional paramedics and volunteers.

review work, suggesting that this takes place largely inside a 'bubble' of localised expertise that is unconnected with more general expertise." (p53)

It is within this broader context of the ambulance industry, that the Panel has considered the issues of workforce health and wellbeing, and workplace culture issues at St John.

1.4 Method and Conduct of the Review

The method and conduct of the review were jointly agreed by the Panel Chair and CEO St John prior to commencement of the review. The intent of the review was to provide independent consideration to St John's Board and Executive on the workplace culture and well-being and support programs, identifying issues and providing recommendations for improvement as per the Terms of Reference.

The Review was advertised internally (via St John email to staff and volunteers 2 June 2015) and externally (*The West Australian* newspaper 3 June 2015) inviting submissions and requests to attend private hearings with the Panel from interested parties. The Panel also wrote to the relevant union (United Voice WA) notifying them of the review and inviting a submission on behalf of their members.

Submissions

The Panel received seventy five written submissions as part of the submission process and private hearings. Due to the nature of the subject matter, all submissions were accepted as confidential and therefore a list of individual submissions has not been provided in this report.

Of the submissions received, seventy nine per cent of individuals were engaged in either paid or a voluntary capacity at St John at the time of submission, thirteen per cent had previously held paid or voluntary positions at St John, and eight per cent were from external groups/individuals.

It is important to note that the Panel has continued to receive information in relation to the Review into 2016. These submissions, while not included in the final figures for 2015 listed above, have been logged and provided to the Panel members for their information.

Private and Confidential Hearings

The Panel held six days of private hearings in Perth and selected rural centres during August and September 2015, at which 26 individuals, and four groups/invited guests attended. Eighty four per cent of the individuals attending private hearings were engaged in either a paid or voluntary capacity at St John at the time of hearings. Eleven per cent had previously held paid or voluntary positions at St John and five per cent were classed as other (invited to present).

Private hearings were allocated forty five minutes per session and provided in a semi structured format, allowing individuals to raise issues pertinent to the review's Terms of Reference. Individuals were requested to consider their recommendations that would support improvement the workplace culture and health and well-being at St Johns as part of their presentation to the Panel.

Consultations and Additional Reports Received

Consultation with St John Executive and the Team Leader for Wellbeing and Support Services were undertaken throughout the review process, and included:

- Tony Ahern (CEO)
- Debbie Jackson (Community Services Director)
- Iwona Niemasik (HR Director)
- Cindy Monteith (Chaplain/Team Leader – Wellbeing and Support Services)

In addition to the formal consultations, a Panel representative was invited to attend the St John Head Office (Communications) and participated in an on road session to meet with staff for informal consultations.

The Panel also gathered evidence from other State emergency agencies, health professionals and representative bodies including:

- Western Australian Police (WAPOL)
- Department of Fire and Emergency Services (DEFES)
- The Hollywood Clinic (Trauma Recovery Program) – Hollywood Private Hospital
- United Voice WA – union representing paramedics

In advance of consultation meetings, the Panel was provided with documentation on:

- St Johns operations
- Wellbeing and Support Department (programs and services)
- Policy and Procedure documentation pertaining to:
    - Recruitment practices and selection processes
    - Employee training and awareness
    - Employee wellbeing linked to critical incidents, bullying, fatigue and stress

The Panel received two major reports for review providing an additional evidence base to develop the Panel's findings and recommendations:

- Chief Psychiatrist Review, Department of Health – St John Ambulance Paramedic and Volunteer Suspected Suicides.
- Phoenix Australia, Centre for Posttraumatic Mental Health – St John Ambulance Review of Workplace Mental Health Risks.

To support procedural fairness, St John was provided a draft final version of the Panel's report to identify factual items requiring correction. Where factual errors were identified, this was corrected in the final version.

1.5 Confidentiality

Throughout this review, all efforts have been made to protect the confidentiality of individuals making representation to the Panel. Individual's contribution information to the Panel via written submission, or participating in the private and confidential hearing process was provided with an undertaking that their contribution would remain confidential. It is for this reason a list of submissions and private hearings has not been provided with this Report. Where groups and individuals have been referred to in the Report, explicit permission has been received by the Panel to do so.

1.6 Timetable

The following timetable provides an outline of the review program and receipt of key reports and information.

Item/Report	Received/Completed
Review commenced	10 April 2015
Public submission opened	2 June 2015
Public submissions closed	15 July 2015
Private Hearings	10 August – 10 September 2015
Reports: Chief Psychiatrist Review St John Ambulance Response to the Chief Psychiatrist Review Phoenix Australia Review	 15 January 2016 26 February 2016 2 March 2016
Draft report completed	28 April 2016
St John Ambulance response to the review	15 June 2016
Final report completed	15 August 2016
Presentation of report outcomes to SJA Board	23 August 2016

Table 2 – Timetable for Review process

The Panel acknowledges that the initial intention was to provide a final report to St John by November 2015. This timeframe was subject to the timely receipt of the *Chief Psychiatrist* and *Phoenix Australia Reports*, both of which were critical to the Panel's deliberations. Both reports were not received by the Panel until early 2016, resulting in a delay in the completion of the final report.

1.7 Limitations of the Review

The Panel is confident it has undertaken a comprehensive review of the issues relating to health and wellbeing of the St John workforce. That said, there are a number of limitations which must be acknowledged.

The consultation process was not intended to provide a representative sample of the St John workforce. With approximately 100 staff voices contributing to the Review, it is only a small proportion of the total workforce and the views expressed cannot be extrapolated across the entire workforce. Readers should therefore, interpret the relevant sections of this Report with this knowledge.

Similarly, it is important to emphasise the subjective nature of the information provided through the consultation process and represented in Chapter 7 of this Report. What appears are the opinions and views put forward by individuals, and the Panel has not attempted to confirm or negate the objectivity of the comments made. Rather, the Panel has attempted to identify key themes raised by the participants and highlight the issues.

The provision of a comprehensive literature review at Chapter 2 shows readers that there is empirical evidence which supports the themes identified through the consultation process.

2 Literature Review

2.1 Background

An ambulance service is an organisation focused on health outcomes. As a consequence, its goals and skills are focused on ensuring the optimal protocols and interventions based on the available scientific literature. Hence, this sector of the emergency services has the capacity to be a leader for the emergency services generally, including in the area of occupational health and the impact of the specific hazards to employees, particularly the mental health impact of the cumulative exposure to traumatic events. There are also statutory obligations for ambulance services to be aware of managing these hazards, based on a thorough knowledge of the published scientific literature. Knowledge of the effects of traumatic stress will also better prepare ambulance officers to manage the victims and relatives of the many tragedies that they confront in their line of duty. Awareness of this body of literature should be core knowledge for those in leadership roles in the emergency services as they fulfil their responsibilities for occupational health and safety.

This literature review is conducted in the setting of a series of suicides of ambulance officers and volunteers. Suicide is a tragic and generally uncommon outcome of psychiatric disorder. It is difficult to predict and has multifactorial causal risk factors related to individual psychological characteristics, neurobiology, and social and occupational determinants[4]. A matrix of these factors will combine to account for suicide but prior suicide attempts and psychiatric illness are the strongest predictor. Therefore, the issue of suicide in occupational settings needs to be examined against a much larger body of literature about the mental health of emergency service workers generally, and the particular risk factors that have been identified from these occupational settings that increase the probability of disorder. In any setting, suicide is a rare outcome and needs to be considered against the background of suicidal ideation and its antecedents.

In reviewing the literature, there is a striking difference between the sophistication and depth of information available about mental health of military personnel and veterans, in contrast to the emergency services. This phenomenon is not only the case in Australia. A substantial reason for the disparity in the quality of these literatures is that Defence organisations are nationally based and subject to significantly greater public scrutiny in terms of the welfare of currently serving members and veterans than are the emergency services. The emergency services are state or city based organisations that are substantially smaller and tend to operate independently, often under separate ministers. At a national level they only operate as a loose linked network. This significantly disrupts the development of a knowledge base that should inform the appropriate practice of occupational health interventions in these settings. It is

[4] Christensen, H., Cuijpers, P., & Reynolds C.F (2016) Changing the direction of suicide prevention research: A need for population impact. *JAMA Psychiatry* Published on line March 16.

important therefore to extract knowledge from a series of domains that will assist in understanding and addressing the risk of suicide in emergency workers, particularly ambulance officers.

2.1.1 Structure of the Literature Review

As psychiatric disorders represent as one of the predominant risk factor for suicide, the literature about the mental health of emergency service personnel is first reviewed. Of particular interest in ambulance officers are the rates of PTSD due to the nature of the occupational risks as well as the high rate of comorbidity of PTSD with major depressive disorder. As physical illness is a further risk factor for suicide, the diseases that are associated with the occupational exposures and their link to the psychiatric disorders arising from traumatic stress exposure is also discussed. This matter is of relevance to older ambulance officers. Against the background of these domains, the difficulty of meaningfully comparing and interpreting the rates of disorders in civilian populations and emergency personnel is explored in the context of healthy work effect.

Many emergency service workers have a history of the progressive development of PTSD symptoms with the passage of time. Hence, subsyndromal disorder is discussed as it represents an opportunity for early intervention. These symptoms are also the cause of impairment in their own right and are a measure that needs to be taken into account when judging the health of an emergency service workforce. The cumulative exposure to traumatic events is then explored as this represents a foreseeable risk factor for PTSD and highlights the risk to emergency service personnel as the duration of their service increases. This cumulative exposure to traumatic events is an independent risk factor for suicidal ideation. However, there are other stresses in the workplace that contribute to the onset of psychiatric disorder and these are briefly reviewed.

As completed suicide is a relatively rare outcome and hence is very difficult to investigate due to the predicative ability of statistical power, completed suicide is discussed against the background of suicidal ideation and its relationship to psychiatric disorder and trauma exposure. The review is then concluded with a specific discussion of the relationship between PTSD and suicidal ideation and attempts, and the prevalence of these phenomena in emergency service personnel. There are a range of other individual and environmental risk factors for suicide, but these are not reviewed as the review focuses on the foreseeable workplace factors that are within the domain of interest to an ambulance service.

2.2 Rates of Disorder in Emergency Service Personnel

In looking at the rates of psychiatric disorder in a workforce population, it is important to emphasise that these rates are indicative of the current workforce. In contrasting these to the rates in the general population, it is clear that individuals who are unwell are likely to leave the workplace. This contrasts to general population studies that represent entire cohorts that are only exited through death or migration. Furthermore,

organisations such as emergency services have recruitment policies that exclude people with a range of existing health complaints. For these reasons, populations such as the military and emergency services should be substantially healthier than the populations from which they are drawn. They also have access to ancillary health services, which should mitigate emerging disorder by offering appropriate treatment and early intervention. The literature about the emergency services and particularly ambulance services should be considered against this background of the "*healthy worker effect*".[5]

Posttraumatic stress disorder (PTSD) is the condition that has been subject to particular focus in the emergency services. Systematic reviews of the evidence indicate that emergency service personnel have a significant risk, more than double the general population, of developing PTSD in the course of their working career.[6] This study reviewed 28 studies and concluded that the worldwide pulled prevalence of PTSD in emergency services was in the order 10%. In particular, it noted that studies of ambulance personnel showed higher prevalence rates of PTSD than firefighters and police officers. The rate of PTSD of 10% for emergency service personnel is compared with 1.3% to 3.5% in populations of diverse countries.

The higher rate amongst ambulance personnel was hypothesised to be a consequence of them being exposed to greater pressure and stress at work than other rescue teams.[7] Other reasons for these higher rates amongst ambulance services are that they respond to more emergency calls than fire fighters and police.[8] Also, the trauma of their job is increased because they have to work in closer proximity with the victims and have the distress of dealing with failed interventions and attempts.[9] These issues highlight the importance of monitoring and managing the cumulative trauma exposure of the ambulance workforce because of the risks it confers.

Studies of ambulance officers also indicate that there is a negative mental health impact of both acute and chronic job stresses. The chronic workload stresses amongst ambulance officers in a study in the Netherlands, when compared to a large reference group, indicated that these had a greater burden in the emergency service

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[5] Larson, G. E., Highfill-McRoy, R. M., & Booth-Kewley, S. (2008). Psychiatric diagnoses in historic and contemporary military cohorts: combat deployment and the healthy warrior effect. *Am J Epidemiol, 167*(11), 1269-1276. doi:10.1093/aje/kwn084

[6] Berger, W., Coutinho, E. S., Figueira, I., Marques-Portella, C., Luz, M. P., Neylan, T. C., & Mendlowicz, M. V. (2012). Rescuers at risk: a systematic review and meta-regression analysis of the worldwide current prevalence and correlates of PTSD in rescue workers. *Soc Psychiatry Psychiatr Epidemiol, 47*(6), 1001-1011. doi:10.1007/s00127-011-0408-2

[7] Young, K. M., & Cooper, C. L. (1995). Occupational stress in the ambulance service: a diagnostic study. *Journal of Management Psychology, 10*, 29-36.

[8] Di Fiorino, M., Massimetti, G., Nencioni, M., & Paoli, R. (2004). Full and subthreshold Post-Traumatic Stress Disorder seven years after a flooding in rescue squads. *Bridging East West Psychiatry, 2*, 18-25.

[9] Jonsson, A., & Segesten, K. (2004). Guilt, shame and need for a container: a study of post-traumatic stress among ambulance personnel. *Accid Emerg Nurs, 12*(4), 215-223. doi:10.1016/j.aaen.2004.05.001

environment.[10] In general however, the literature emphasises that the rates in these populations need to be considered against the mitigating factors of pre-employment selection, training in stress management and the early interventions that exist within these organisations.[11]

One systematic review specifically examined the health status of ambulance services[12] and specifically looked at the question of PTSD. One high quality Swedish study of a representative of the ambulance workforce concluded that the prevalence of PTSD symptoms amongst ambulance personnel was 21.5% compared with the general population of 2.6%.[13] Systematically reviewing the literature, Sterud et al[12] concluded that, *"The prevalence of PTSD symptoms are consistently high in regular ambulance services, about 20% of ambulance workers in 5 of 7 studies"*. They also identified the importance of considering the prevalence of depression and anxiety disorders and concluded that in four out of five studies, 20% of ambulance service workers had psychopathological problems. This study also highlighted that the lifetime burden of these disorders led to early retirement in a significant portion of the work force. These matters should be assessed and managed by an ambulance service with appropriate financial and career support for those who are injured in the course of their duties, according to the legislated provisions.

In summary, ambulance workers as a consequence of both mental health and physical problems were identified as having a higher risk of permanent medical impairment and early retirement on medical grounds than other occupational groups. The relationship between physical and psychological morbidity requires a brief review because of their shared origins and combined impact on impairment.

2.3 Physical Health of Emergency Service Personnel

In regards to the issue of medical conditions, several studies have also suggested, although the data was not conclusive, that ambulance workers have higher risks of mortality and fatal accidents when compared with the general population. In this context, it is important to identify that posttraumatic stress disorder and major depressive disorder were significant risk factors for the development of cardiovascular disease.[14] The role of PTSD is mediated both by it being a risk factor for

[10] van der Ploeg, E., & Kleber, R. J. (2003). Acute and chronic job stressors among ambulance personnel: predictors of health symptoms. *Occup Environ Med, 60 Suppl 1*, i40-46.

[11] Skogstad, M., Skorstad, M., Lie, A., Conradi, H. S., Heir, T., & Weisaeth, L. (2013). Work-related post-traumatic stress disorder. *Occup Med (Lond), 63*(3), 175-182. doi:10.1093/occmed/kqt003

[12] Sterud, T., Ekeberg, O., & Hem, E. (2006). Health status in the ambulance services: a systematic review. *BMC Health Serv Res, 6*, 82. doi:10.1186/1472-6963-6-82

[13] Jonsson, A., Segesten, K., & Mattsson, B. (2003). Post-traumatic stress among Swedish ambulance personnel. *Emerg Med J, 20*(1), 79-84.

[14] Edmondson, D., & Cohen, B. E. (2013). Posttraumatic stress disorder and cardiovascular disease. *Prog Cardiovasc Dis, 55*(6), 548-556.

hyperlipidaemia and hypertension.[15] A major depressive disorder is similarly recognised as a significant risk factor for the onset and course of cardiac disease, leading to clinical guidelines about screening for psychiatric disorders and in particular, depression in patients with coronary episodes.[16]

A further well established relationship of relevance is between somatic symptoms such as back pain and posttraumatic stress disorder.[17] Musculoskeletal injury is a common cause of morbidity and impairment in ambulance officers due to the physical demands such as lifting, in the course of their employment. In general, individuals with posttraumatic stress disorder are prone to greater distress and impairment in relation to their physical injuries.[18] [19]

The recovery from injury is also impacted upon due to the mutual maintenance of PTSD and pain.[20] The risk of somatisation becomes increasingly apparent with further trauma exposures, an important issue during a prolonged career in the ambulance service.[21] Hence, there is a substantial body of evidence about the probable role of psychosocial factors including depression and PTSD, a relationship that is relevant to the patterns of recovery of injured ambulance officers.[22] The rehabilitation of ambulance officers with physical injuries should pay particular attention to the possibility of comorbid psychological disorders. These medical comorbidities are of further importance as chronic medical illnesses are risk factors for suicidal ideation and

[15] Levine, A. B., Levine, L. M., & Levine, T. B. (2014). Posttraumatic stress disorder and cardiometabolic disease. *Cardiology, 127*(1), 1-19.

[16] Lichtman, J. H., Bigger, J. T., Jr., Blumenthal, J. A., Frasure-Smith, N., Kaufmann, P. G., & Lesperance, F. (2008). Depression and coronary heart disease: recommendations for screening, referral, and treatment: a science advisory from the American Heart Association Prevention Committee of the Council on Cardiovascular Nursing, Council on Clinical Cardiology, Council on Epidemiology and Prevention, and Interdisciplinary Council on Quality of Care and Outcomes Research: endorsed by the American Psychiatric Association. *Circulation, 118*(17), 1768-1775.

[17] McFarlane, A. C. (2007). Stress-related musculoskeletal pain. *Best Pract Res Clin Rheumatol, 21*(3), 549-565.

[18] Gupta, M. A. (2013). Review of somatic symptoms in post-traumatic stress disorder. *Int Rev Psychiatry, 25*(1), 86-99.

[19] Pietrzak, R. H., Goldstein, R. B., Southwick, S. M., & Grant, B. F. (2012). Physical health conditions associated with posttraumatic stress disorder in U.S. older adults: results from wave 2 of the National Epidemiologic Survey on Alcohol and Related Conditions. *J Am Geriatr Soc, 60*(2), 296-303.

[20] Liedl, A., O'Donnell, M., Creamer, M., Silove, D., McFarlane, A., Knaevelsrud, C., & Bryant, R. A. (2010). Support for the mutual maintenance of pain and post-traumatic stress disorder symptoms. *Psychol Med, 40*(7), 1215-1223.

[21] Killgore, W. D., Stetz, M. C., Castro, C. A., & Hoge, C. W. (2006). The effects of prior combat experience on the expression of somatic and affective symptoms in deploying soldiers. *J Psychosom Res, 60*(4), 379-385.

[22] McLean, S. A., Clauw, D. J., Abelson, J. L., & Liberzon, I. (2005). The development of persistent pain and psychological morbidity after motor vehicle collision: integrating the potential role of stress response systems into a biopsychosocial model. *Psychosom Med, 67*(5), 783-790.

completed suicide.[23] These are likely to be more prevalent as an ambulance officer ages, a factor that should be anticipated in workforce management.

2.4 Comparisons of Health with the General Population and other Occupational Groups

These probable rates of psychiatric disorder in ambulance workers require further discussion against the background of the known prevalence of mental disorder in the Australian community. There have now been two national surveys on health and wellbeing. The first was conducted in 1997 and the second in 2007.[24] This demonstrated that almost half of the population (45.5% of the Australian population) will experience mental disorder at some point in their lifetime and that one in five will have experienced a disorder in the previous 12-months. In general, the prevalence of mental disorders declines in middle age.

In a 12-month period, 11.9% of the population used mental health services of some form or another. Many will have sought assistance but the nature of their mental health difficulties will not have been adequately understood or diagnosed. Posttraumatic stress disorder was the most common mental disorder with a prevalence of 6.4% in the 2007 Australian prevalence study. People employed in the workforce had a prevalence of mental disorder of 18.7%.[24] Ambulance officers will be subject to the same range of factors in their private lives above and beyond employment, that impact on mental health in the general population.

The largest workforce study of mental disorders in Australia was conducted in 2010 of the Australian Defence Force (McFarlane et al, 2011).[25] This survey identified that the Australian Defence Force had a 12-month prevalence of 22% of disorder. Depressive disorders were found to be more common than in the general community. Similarly to the WA Ambulance service, a selection process is in place prior to employment. A major risk factor for PTSD was the many trauma exposures that occur as part of that occupational group. As a consequence of this known risk of psychological morbidity, major reforms and services have been put in place to improve the quality of care, reduce stigma and screen this population.[26]

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[23] Erlangsen A, Stenager E, Conwell Y. (2005) Physical diseases as predictors of suicide in older adults: a nationwide, register-based cohort study. *Soc Psychiatric Epidemiology*, 5:1427-39.

[24] Slade, T., Johnston, A., Teesson, M., Whiteford, H., Burgess, P., Pirkis, J., & Saw, S. (2009). *The Mental Health of Australians 2. Report on the 2007 National Survey of Mental Health and Wellbeing*. Canberra: Department of Health and Ageing.

[25] McFarlane, A. C., Hodson, S. E., Van Hooff, M., & Davies, C. (2011). *Mental Health in the Australian Defence Force: 2010 ADF Mental Health Prevalence and Wellbeing Study*. Canberra: Department of Defence.

[26] Dunt, D. (2009). *Review of Mental Health Care in the ADF and Transition through Discharge*. Retrieved from http://www.defence.gov.au/health/DMH/docs/ReviewofMentalHealth1May09.pdf

However, there are significant challenges in interpreting the relative rates of psychiatric disorder between groups such as the emergency services or the military and the general population due to the healthy worker effect.[27] These differences make epidemiological comparisons of disorder prevalence between occupation groups and the community difficult to interpret. Also, the rates of disorder and suicidal behaviour in the general community are matters of major public concern and the issues of whether they are different for the emergency services obfuscates the appropriate focus on how these occupations contribute to suicide risk and psychiatric disorder.

The Issue of SubSyndromal PTSD

A focus on the rates of disorder also does not address the known issue of suicidal ideation and behaviour with lower levels of psychological distress. Therefore, the rates of a diagnosable PTSD in ambulance workers need to be considered against a substantial body of literature about subsyndromal PTSD. With subsyndromal PTSD individuals report levels of symptoms that are just below the threshold required to reach the DSM diagnostic criteria. Subsyndromal PTSD has been identified as being a significant risk factor for the later emergence of the full-blown PTSD.[28] Similarly in civilian samples, the significance of subsyndromal PTSD has been identified in relation to the consequent impairment and suicidal ideation.[29] Pietrzak et al[30] highlighted the significance of these symptoms in emergency service personnel, finding that while 5.4% had full-blown PTSD, 15.4% experienced subsyndromal PTSD. There were significant associations with alcohol abuse and somatic symptoms in both the full PTSD and subsyndromal groups. Similar patterns are likely to exist among ambulance officers/paramedics.

In a study of the Australian Defence Force the predictable trajectory of subsyndromal symptoms across the spectrum of morbidity was identified.[31] In particular the evidence suggests that a significant percentage of individuals exposed to traumatic events will

[27] Larson, G. E., Highfill-McRoy, R. M., & Booth-Kewley, S. (2008). Psychiatric diagnoses in historic and contemporary military cohorts: combat deployment and the healthy warrior effect. *Am J Epidemiol, 167*(11), 1269-1276.

[28] Smid, G. E., Mooren, T. T., van der Mast, R. C., Gersons, B. P., & Kleber, R. J. (2009). Delayed posttraumatic stress disorder: systematic review, meta-analysis, and meta-regression analysis of prospective studies. *J Clin Psychiatry, 70*(11), 1572-1582.

[29] Marshall, R. D., Olfson, M., Hellman, F., Blanco, C., Guardino, M., & Struening, E. L. (2001). Comorbidity, impairment, and suicidality in subthreshold PTSD. *Am J Psychiatry, 158*(9), 1467-1473.

[30] Pietrzak, R. H., Schechter, C. B., Bromet, E. J., Katz, C. L., Reissman, D. B., Ozbay, F, Southwick, S. M. (2012). The burden of full and subsyndromal posttraumatic stress disorder among police involved in the World Trade Center rescue and recovery effort. *J Psychiatr Res, 46*(7), 835-842.

[31] McFarlane, A. C., Hodson, S. E., Van Hooff, M., & Davies, C. (2011). *Mental Health in the Australian Defence Force: 2010 ADF Mental Health Prevalence and Wellbeing Study*. Canberra: Department of Defence.

have a progressive recruitment of symptoms with the passage of time.[19] [32] These future risks highlight the importance of early identification of such symptoms, particularly in emergency service workers, such as ambulance officers due to the predictable further risks arising from ongoing trauma exposures. Even brief periods of symptoms are indicative of risk. Symptoms experienced by paramedics following a traumatic incident that lasts for more than two days, are predictor of long-term morbidity.[33] Hence, these early signs of distress should not be normalised or minimised because of their potential to predict long term risk and are potential targets for early intervention.

The recently published Guidelines for the, "Diagnosis and Treatment of PTSD in Emergency Service Workers" in NSW stated, "*Subsyndromal symptoms of PTSD are relatively common amongst emergency workers and associated with a range of adverse outcomes. Early intervention should be considered in emergency workers with persistent or distressing subsyndromal symptoms*".[34] This highlights that it is not only full-blown PTSD but also that subsyndromal symptoms are relevant to understanding the risks of suicide in St John's ambulance employees.

2.5 The Issue of Cumulative Exposure

There is a significant body of literature that highlights the risk of psychological disorders associated with the burden of increasing trauma exposure[35] which will logically be related to the length of service in the emergency services.[34] This cumulative impact of trauma exposure that increases the risk of PTSD is an important issue to consider when managing an ambulance workforce.[36]

Population studies show that the number of trauma exposures increases the risk for posttraumatic stress disorder and other adverse health outcomes.[37] In emergency service personnel it is not simply exposure to a single traumatic event but repeated trauma exposure that result in the neurobiological dysregulation that underpins the emergence of clinical disorder.[35] Thus, it is important to consider lifetime trauma

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[32] O'Donnell, M. L., Varker, T., Creamer, M., Fletcher, S., McFarlane, A. C., Silove, D., Forbes, D. (2013). Exploration of delayed-onset posttraumatic stress disorder after severe injury. *Psychosom Med, 75*(1), 68-75.

[33] Halpern, J. Maunder, R.G., Schwartz, B., & Gurevich, M. (2011) Identifying risks for emotional sequelae after critical incidents, *Emergency Medicine Journal*, 28:51-56.

[34] Harvey, S. B., Devilly, G. J., Forbes, D., Glozier, N., McFarlane, A., Phillips, J., Bryant, R. (2015). Expert Guidelines: Diagnosis and Treatment of PTSD in Emergency Service Workers. Retrieved from http://www.blackdoginstitute.org.au/docs/PTSD_Guidelines_final.pdf

[35] McFarlane, A. C. (2010). The delayed and cumulative consequences of traumatic stress: Challenges and issues in compensation settings. *Psychology, Injury and Law, 3*(2), 100-110.

[36] Karam, E. G., Friedman, M. J., Hill, E. D., Kessler, R. C., McLaughlin, K. A., Petukhova, M.,Koenen, K. C. (2014). Cumulative traumas and risk thresholds: 12-month PTSD in the World Mental Health (WMH) surveys. *Depress Anxiety, 31*(2), 130-142.

[37] Del Gaizo, A. L., Elhai, J. D., & Weaver, T. L. (2011). Posttraumatic stress disorder, poor physical health and substance use behaviors in a national trauma-exposed sample. *Psychiatry Res, 188*(3), 390-395.

history accumulated in the course of an emergency service career and the risk of psychiatric disorder. In discussing the effects of cumulative stress, exposure to traumatic events needs to be distinguished from day to day stressors that have a shorter window of effect and do not have the same cumulative impact that lasts across the life span.

Studies of veterans have similarly demonstrated that lifetime trauma exposures are predictors of both PTSD and depressive symptoms over and above the effects of combat experiences.[38] [39] The impact of 'cumulative trauma' is also related to the number of trauma types experienced with the greater the range of traumas leading to greater probability of disorder in veterans.[40] A longitudinal study of a civilian population similarly found that the effect of trauma is cumulative, in that previous exposure to trauma signals a greater risk of mental disorder from subsequent trauma.[41] Similar patterns of risk have been identified in emergency service personnel.[42] [43]

One further study also highlights the potential long-term impact of traumatic exposures on health workers of major disasters.[44] A 12-year follow up of emergency medical service staff that attended the World Trade Centre disaster on 11 September 2001, highlighted that in twelve-years the prevalence of posttraumatic stress disorder was 7%, probable depression 16% and harmful alcohol usage 3%. These rates were significantly higher in those who arrived early at the disaster site than in a comparative group of unexposed emergency medical service workers. Hence, an ambulance service needs to be particularly aware of the potential long-term costs from a psychological and health perspective of major disasters that may have occurred within that community.

In these underlying mechanisms, further traumatic stress exposures increase the probability of symptoms by strengthening the conditioned link between the traumatic

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[38] Dedert, E. A., Green, K. T., Calhoun, P. S., Yoash-Gantz, R., Taber, K. H., Mumford, M. M., & Beckham, J. C. (2009). Association of trauma exposure with psychiatric morbidity in military veterans who have served since September 11, 2001. *J Psychiatr Res, 43*(9), 830-836.

[39] Iversen, A. C., Fear, N. T., Ehlers, A., Hacker Hughes, J., Hull, L., Earnshaw, M., & Hotopf, M. (2008). Risk factors for post-traumatic stress disorder among UK Armed Forces personnel. *Psychol Med, 38*(4), 511-522.

[40] Cabrera, O. A., Hoge, C. W., Bliese, P. D., Castro, C. A., & Messer, S. C. (2007). Childhood adversity and combat as predictors of depression and post-traumatic stress in deployed troops. *Am J Prev Med, 33*(2), 77-82.

[41] Breslau, N., Chilcoat, H. D., Kessler, R. C., & Davis, G. C. (1999). Previous exposure to trauma and PTSD effects of subsequent trauma: results from the Detroit Area Survey of Trauma. *Am J Psychiatry, 156*(6), 902-907.

[42] Jonsson, A., Segesten, K., & Mattsson, B. (2003). Post-traumatic stress among Swedish ambulance personnel. *Emerg Med J, 20*(1), 79-84.

[43] Wagner, D., Heinrichs, M., & Ehlert, U. (1998). Prevalence of symptoms of posttraumatic stress disorder in German professional firefighters. *Am J Psychiatry, 155*(12), 1727-1732.

[44] Yip J, Zeig-Owens R, Webber MP, Kablanian A, Hall CB, Vossbrinck M, Liu X, Weakley J, Schwartz T, Kelly KJ, & Prezant DJ. (2016) World Trade Center-related physical and mental health burden among New York City Fire Department emergency medical service workers. *Occup Environ Med*.;73:13-20.

memories and fear and horror responses. Basic behavioural principles highlight that subsequent exposures will strengthen the conditioned association between trauma and the patterns of hyperarousal that are central to posttraumatic stress disorder.[45] These are underpinned by the dysregulation of a range of neurobiological systems. There is substantial literature, that posttraumatic stress disorder involves long lasting alterations in a range of biological systems via the mechanisms of stress sensitisation and fear conditioning.[46] These mechanisms are likely to play a central role in the cumulative burden of exposures for ambulance officers.

In summary, the cumulative burden of trauma exposure is an important risk factor that should be anticipated and managed in relation to the predictable rates of psychological injury and the related risk of suicide in ambulance officers.

2.6 Other Occupational Stresses and Disorder

There is a broader literature that has also looked more specifically at general work factors associated with the predictions of health symptoms. For example, a study of Dutch ambulance officers[47] concluded that, *"Especially social aspects of the work environment were important predictors, in particular lack of social support from colleagues, lack of social support from supervisors and finally poor communication. These factors were found to be significant predictors of posttraumatic stress disorder response, burnout symptoms and fatigue"* (p144). This led these authors to conclude, *"Therefore improving job circumstances is more a matter of improving the social climate, and enhancing acknowledgement as well attention – in short management of organizational procedures and technical elements"* (p145).

Other studies have also examined the impact of duration of service on the health and welfare of officers.[48] This study highlighted that approximately one third of the sample had high levels of psychopathology, including burnout and posttraumatic symptoms. These outcomes were associated with a longer time in service, less recovery time between incidents and more frequent exposure to incidents. This study highlighted an important issue, namely that more experienced staff were expected to cope better and as a consequence were more reluctant to express their distress. It highlighted that managerial staff had tended to be less alert to the needs of these experienced staff and the early warning signs of difficulties in this group.

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[45] Pitman, R. K., Rasmusson, A. M., Koenen, K. C., Shin, L. M., Orr, S. P., Gilbertson, M. W., Liberzon, I. (2012). Biological studies of post-traumatic stress disorder. *Nat Rev Neurosci, 13*(11), 769-787.

[46] Charney, D. S., Deutch, A. Y., Krystal, J. H., Southwick, S. M., & Davis, M. (1993). Psychobiologic mechanisms of posttraumatic stress disorder. *Arch Gen Psychiatry, 50*(4), 295-305.

[47] van der Ploeg, E., & Kleber, R. J. (2003). Acute and chronic job stressors among ambulance personnel: predictors of health symptoms. *Occup Environ Med, 60 Suppl 1*, i40-46.

[48] Alexander, D. A., & Klein, S. (2001). Ambulance personnel and critical incidents: impact of accident and emergency work on mental health and emotional well-being. *Br J Psychiatry, 178*(1), 76-81.

It further highlighted that particular types of incidents needed to be identified as having a greater probability of being, *"psychonoxious"*. For example motor accidents, particularly those involving children or victims known to the ambulance personnel were unusually challenging. The importance for recovery time was also highlighted for officers who had attended particularly difficult jobs. The possibility of the cumulative impact was an important issue to identify by management. Another study similarly identified the importance of occupational stresses, the frequency of tending traumatic incidents and length of service as predictor of outcome.[49] This led the authors to conclude that both organisational and individual based interventions played an important role in managing the risk of posttraumatic stress disorder and other psychological disorders in ambulance services.

The mental health consequences of bullying and harassment have been well documented in a variety of occupations.[50] It was noteworthy that this Australian review of this information for an emergency service highlighted that senior management had concerns about bullying. There is an extensive literature highlighting the mental health consequences of bullying and sexual harassment. These include the risks of suicide.[51] The consequences on physical and mental health of sexual harassment and discrimination have been long identified.[52] Similarly, the impact of bullying on mental health has long been recognised.[53]

In conclusion, as was found in one British study of ambulance workers with rates of approximately 22% having a disorder[54], adverse stress reactions are difficult to predict on the basis of work-related or individual factors alone in isolation. These need to be considered against the background of the role of broader organisational factors that contribute to psychological distress. Hence, the adverse health outcomes of a career of an ambulance officer are related to a matrix of factors, including the cumulative traumatic stress involved in the role, organisational factors and individual risk factors. A similar matrix is likely to contribute to the risk of suicide.

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[49] Bennett, P., Williams, Y., Page, N., Hood, K., Woollard, M., & Vetter, N. (2005). Associations between organisational and incident factors and emotional distress in emergency ambulance personnel. *Br J Clin Psychol, 44*(Pt 2), 215-226.

[50] Lynch, J. (2002). *Workplace bullying: Implications for police organisations*. Australasian Centre for Policing Research: Marden, South Australia.

[51] Einarsen, S., Hellesoy, O. H., Raknes, B. I., & Matthiesen, S. B. (1994). *Bullying and Harsh Personalized Conflicts: Unhealthy Interaction at Work*. Bergen, Norway: Sigma Forlag.

[52] Shrier, D. K. (1990). Sexual harassment and discrimination. Impact on physical and mental health. *N J Med, 87*(2), 105-107.

[53] Nielsen, M. B., & Einarsen, S. (2012). Outcomes of exposure to workplace bullying: a meta-analytic review. *Work & Stress, 26*(4), 309-332.

[54] Bennett, P., Williams, Y., Page, N., Hood, K., & Woollard, M. (2004). Levels of mental health problems among UK emergency ambulance workers. *Emerg Med J, 21*(2), 235-236.

2.7 Suicide and Psychiatric Disorder

Ambulance officers and emergency service workers are occupational groups who evoke special concerns about the rates of suicide, but this needs to be considered against the known risk of psychiatric disorder for suicide.[55] While the career of ambulance officers involves the occupational exposures that are specific risk factors for suicide, this needs to be considered against the more general literature about the known relationship between suicide and psychiatric disorder. In the general community, approximately 90% of people who attempt suicide have a psychiatric disorder.[56] [57] [58] Mood disorders are an antecedent to 30–90% of suicide mortalities.[59] [60] [61] Substance-related disorders are also present in 26–55% of those who die by suicide and are the second highest group of mental disorders associated with suicide.[61] It is important to recognise that PTSD is only one of the psychiatric disorders that will exist among ambulance officers that lead to the risk of suicide. Hence any prevention strategy needs to recognise the risk associated with a range of disorders that may or may not be work related. Depression and alcohol abuse are also disorders that occur with greater prevalence among ambulance officers because of the role occupational exposures play in their aetiology.

2.8 Suicidal Ideation and Attempts

In view of the fact that attempted suicide is much more common than completed suicide, investigation of associated risk factors of non-fatal suicidal behaviour, particularly when accompanied by co-morbid psychiatric disorder, is an important issue for consideration. Suicidal ideation and attempt are integral symptomatology for a number of psychiatric disorders. Loss of self-esteem, inability to anticipate a future and loss of connectedness are common preoccupations in those who have a mental disorder. These states of mind lead into profound feelings of worthlessness and fleeting suicidal thoughts that lead to planning a suicide attempt. A significant body of evidence supports a continuum of suicidal expression, where non-fatal suicidality, (i.e., suicidal ideation, suicidal plans and attempts) predominantly precede future completed

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[55] Stuart, H. (2008). Suicidality among police. *Curr Opin Psychiatry, 21*(5), 505-509.

[56] Krysinska, K., & Lester, D. (2010). Post-traumatic stress disorder and suicide risk: a systematic review. *Arch Suicide Res, 14*(1), 1-23.

[57] Marshall, R. D., Olfson, M., Hellman, F., Blanco, C., Guardino, M., & Struening, E. L. (2001). Comorbidity, impairment, and suicidality in subthreshold PTSD. *Am J Psychiatry, 158*(9), 1467-1473.

[58] Oquendo, M., Brent, D. A., Birmaher, B., Greenhill, L., Kolko, D., Stanley, B. & Mann, J. J. (2005). Posttraumatic stress disorder comorbid with major depression: factors mediating the association with suicidal behavior. *Am J Psychiatry, 162*(3), 560-566.

[59] Arsenault-Lapierre, G., Kim, C., & Turecki, G. (2004). Psychiatric diagnoses in 3275 suicides: a meta-analysis. *BMC Psychiatry, 4*, 37.

[60] Kang, H. K., & Bullman, T. A. (2008). Risk of suicide among US veterans after returning from the Iraq or Afghanistan war zones. *JAMA, 300*(6), 652-653.

[61] Rihmer, Z. (2007). Suicide risk in mood disorders. *Curr Opin Psychiatry, 20*(1), 17-22.

suicide.[62] [63] Thus, focusing on suicidal thoughts and behaviours provides effective opportunities to prevent suicide deaths.

A study compared the Australian Defence Force (ADF) with the general community (ABS).[64] The prevalence of suicidal ideation (3.9% versus 1.7%, difference in proportion ADF–ABS=2.2, 95% CI 1.6, 2.8) and making a suicide plan (1.1% versus 0.4%, difference in proportion ADF–ABS=0.7 95% CI 0.5, 1.0) was significantly higher in the ADF compared to the Australian community, with the rate of suicidality in the ADF being more than double that in the general community. This was despite the rates of psychiatric disorder not being substantially different. However, the ADF reported the same prevalence of suicide attempts (0.4%) in the preceding twelve months as the general community (0.3%). These higher rates of suicidal ideations may have been accounted for by the greater trauma exposure of the defence population, and the higher rates of PTSD and major depressive disorder. Such thoughts and behaviours were not only important predictors of fatal suicide but also were the focus of public health interventions in their own right.[65]

Community-based research highlights 38% of the risk of suicidal ideation is associated with exposure to traumatic events, and that suicidal ideation and suicide attempt are more likely among people who have experiences specific trauma.[66] [67] [68] Importantly, these relationships are independent of psychiatric disorders. Studies show a positive relationship between cumulative trauma exposure and likelihood of suicidality.[69] This cumulative effect of exposure may explain why a past history of active military service

[62] De Leo, D., Cerin, E., Spathonis, K., & Burgis, S. (2005). Lifetime risk of suicide ideation and attempts in an Australian community: prevalence, suicidal process, and help-seeking behaviour. *J Affect Disord, 86*(2-3), 215-224.

[63] Joiner, T. E., Jr., Conwell, Y., Fitzpatrick, K. K., Witte, T. K., Schmidt, N. B., Berlim, M. T., & Rudd, M. D. (2005). Four studies on how past and current suicidality relate even when "everything but the kitchen sink" is covaried. *J Abnorm Psychol, 114*(2), 291-303.

[64] McFarlane, A. C., Hodson, S. E., Van Hooff, M., & Davies, C. (2011). *Mental Health in the Australian Defence Force: 2010 ADF Mental Health Prevalence and Wellbeing Study*. Canberra: Department of Defence.

[65] Johnston, A. K., Pirkis, J. E., & Burgess, P. M. (2009). Suicidal thoughts and behaviours among Australian adults: findings from the 2007 National Survey of Mental Health and Wellbeing. *Aust N Z J Psychiatry, 43*(7), 635-643.

[66] Belik, S. L., Cox, B. J., Stein, M. B., Asmundson, G. J., & Sareen, J. (2007). Traumatic events and suicidal behavior: results from a national mental health survey. *J Nerv Ment Dis, 195*(4), 342-349.

[67] Goldney, R. D., Wilson, D., Dal Grande, E., Fisher, L. J., & McFarlane, A. C. (2000). Suicidal ideation in a random community sample: attributable risk due to depression and psychosocial and traumatic events. *Aust N Z J Psychiatry, 34*(1), 98-106.

[68] Stein, D. J., Chiu, W. T., Hwang, I., Kessler, R. C., Sampson, N., Alonso, J.,& Nock, M. K. (2010). Cross-national analysis of the associations between traumatic events and suicidal behavior: findings from the WHO World Mental Health Surveys. *PLoS One, 5*(5), e1057.

[69] Pizarro, J., Silver, R. C., & Prause, J. (2006). Physical and mental health costs of traumatic war experiences among Civil War veterans. *Arch Gen Psychiatry, 63*(2), 193-200.

was a risk factor for suicidal ideation in fire fighters.[70] There are other clinically relevant interactions, for example, depression when comorbid with PTSD is an important contributor to the risk of suicide.[71] Furthermore, suicide ideation in individuals with depression is also predicted by traumatic exposures.[72] Importantly, the risk of suicidal ideation and behaviour increases further with the passage of time, highlighting the importance of early intervention.[73]

Help-seeking is adversely impacted by perceived barriers and stigma associated with stress, emotional, mental health or other problems[74] and these undermine the opportunities for managing the risk of suicide. Equally bullying and hazing are also risk factors for suicidal ideation. While there are few studies in general, serious hazing or bullying are related to suicide.[75] Hence, the reflection of these general risk factors for suicide and suicidal ideation in emergency service populations is matter central to this review.

2.9 Posttraumatic stress disorder and suicide risk

The role of PTSD and the risk of suicide have been examined in a variety of settings. The specific relationship between suicidal ideation and PTSD has been most extensively examined. A meta-analysis of 50 articles found that PTSD was associated with an increased incident of attempted suicide and prior and current suicidal ideation.[56] This relationship remained when controlling for the presence of comorbid psychiatric disorders, such as major depressive disorder. It was difficult to reach a definitive conclusion about the issue of completed suicide with PTSD due to the lack of statistical power. A similar systematic review of suicidality and PTSD in adolescents found a strong association between posttraumatic stress disorder and suicidality.[76] This noted that in adolescents, the rates of suicidal ideation ranged between 30% and 80% of adolescents with PTSD.

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[70] Stanley, I. H., Hom, M. A., Hagan, C. R., & Joiner, T. E. (2015). Career prevalence and correlates of suicidal thoughts and behaviors among firefighters. *J Affect Disord, 187*, 163-171.

[71] Ramberg, M., Stanley, B., Ystgaard, M., & Mehlum, L. (2015). Depressed suicide attempters with posttraumatic stress disorder. *Arch Suicide Res, 19*(1), 48-59.

[72] Jeon, H. J., Park, J. I., Fava, M., Mischoulon, D., Sohn, J. H., Seong, S., Cho, M. J. (2014). Feelings of worthlessness, traumatic experience, and their comorbidity in relation to lifetime suicide attempt in community adults with major depressive disorder. *J Affect Disord, 166*, 206-212.

[73] Madsen, T., Karstoft, K. I., Bertelsen, M., & Andersen, S. B. (2014). Postdeployment suicidal ideations and trajectories of posttraumatic stress disorder in Danish soldiers: a 3-year follow-up of the USPER study. *J Clin Psychiatry, 75*(9), 994-1000.

[74] Hoge, C. W., Castro, C. A., Messer, S. C., McGurk, D., Cotting, D. I., & Koffman, R. L. (2004). Combat duty in Iraq and Afghanistan, mental health problems, and barriers to care. *N Engl J Med, 351*(1), 13-22.

[75] Ostvik, K., & Rudmin, F. (2001). Bullying and hazing among Norwegian army soldiers: Two studies of prevalence, context, and cognition. *Military Psychology, 13*(1), 17-39.

[76] Panagioti, M., Gooding, P. A., Triantafyllou, K., & Tarrier, N. (2015). Suicidality and posttraumatic stress disorder (PTSD) in adolescents: a systematic review and meta-analysis. *Soc Psychiatry Psychiatr Epidemiol, 50*(4), 525-537.

Further research has been conducted across the aggregated body of the World Mental Health Survey to examine the role of trauma in suicidal behaviours.[68] Importantly, this study found a dose response relationship between the number of traumatic events and suicidal ideation and attempts. These data provide further evidence about the cumulative burden of trauma exposure. However, with multiple trauma exposures, the size of the association slowly diminished.

Suicidal behaviour in military and veteran populations is also of interest due to similarities to the emergency service in terms of occupational stressors. A systematic review of military and veteran studies screened 80 peer-reviewed articles, of which 16 were suitable for further analysis.[77] The authors concluded that suffering from posttraumatic stress disorder was associated with "*higher rates of morbidity and mortality and the increased risk of suicidal behaviour".* Their primary conclusions were that the exposures to a combat environment were a risk factor for developing PTSD and suicidal behaviour. In particular, multiple exposures in the battlefield were associated with higher rates of morbidity caused by suicide.[78] In a study of Australian defence, personnel identified particular experiences including witnessing an attempted suicide or suicide increased the probability of suicide attempts.[79] A trend of increasing severity of suicidal ideation and behaviour was evident as the number of different types of trauma accumulated.

This issue was specifically studied in Australian Vietnam veterans who were directly compared with sex and aged Australian population. There was a significantly greater risk for suicidal ideation (7.9), planning (9.7), and attempts, 13.8 times higher for the veterans in contrast to the Australian population. PTSD, depression, alcohol disorder, phobia and agoraphobia were prominent predictors.[80]

The role of psychological trauma in suicidal ideation and attempts has also been examined in general population studies such as in a nationally represented sample of USA citizens.[81] Posttraumatic stress disorder was the only anxiety disorder that had a specific association with suicidal ideation and suicide attempts when confounds such as socio-demographics, mood disorders, and substance abuse were controlled for. A further body of research with a later national representative sample in the USA of 34,653 people investigated the type and number of traumas associated with suicide

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[77] Pompili, M., Sher, L., Serafini, G., Forte, A., Innamorati, M., Dominici, G., .Girardi, P. (2013). Posttraumatic stress disorder and suicide risk among veterans: a literature review. *J Nerv Ment Dis, 201*(9), 802-812.

[78] Boscarino, J. A. (1997). Diseases among men 20 years after exposure to severe stress: implications for clinical research and medical care. *Psychosom Med, 59*(6), 605-614.

[79] Fairweather-Schmidt, K., Van Hooff, M., & McFarlane, A. (2012). *Suicidality in the Australian Defence Force: Results from the 2010 ADF Mental Health Prevalence and Wellbeing Survey, Report to the Australian Department of Defence*.

[80] O'Toole, B. I., Orreal-Scarborough, T., Johnston, D., Catts, S. V., & Outram, S. (2015). Suicidality in Australian Vietnam veterans and their partners. *J Psychiatr Res, 65*, 30-36.

[81] Sareen, J., Houlahan, T., Cox, B. J., & Asmundson, G. J. (2005). Anxiety disorders associated with suicidal ideation and suicide attempts in the National Comorbidity Survey. *J Nerv Ment Dis, 193*(7), 450-454.

attempts in posttraumatic stress disorder.[82]

This study found that most traumas were associated with greater suicidal ideation and attempts in individuals with posttraumatic stress disorder compared with individuals with no history of trauma exposure or those with trauma exposure but not with PTSD. An important finding was that multiple traumas increased suicidality. Each additional trauma was associated with an increase of 20.1% in the rate of suicidal ideation and 38.9% in the rate of suicide attempts. They highlighted that this finding was in the context of PTSD independently contributing to suicidality above and beyond the impact of trauma alone, an effect in the order of 2 to 5 times.[83] Victims of assault, violence and having had a role as a peacekeeper had similarly high rates of suicide attempts and behaviour, ,which was attributed to an increase in a sense of social isolation, as well as being habituated to a greater degree of pain tolerance and fearlessness of death through repeated exposure.

Childhood maltreatment is another specific trauma that has been identified as a significant risk factor for suicidal behaviours. This relationship exists in the absence of PTSD but where PTSD increases the severity of the associated risk.[84]

In summary PTSD has been shown to have an increased rate of suicidality in many population studies, in part but not solely because of its comorbidity with major depressive disorder and alcohol abuse. Posttraumatic stress disorder is also related to suicidal behaviour, with 20% of community samples attempting suicide at least once.[85] [86] Similarly, in civilian samples, the significance of subsyndromal PTSD has been identified in relation to the consequent impairment and suicidal ideation.[87] The literature highlights the relationship between cumulative stress exposure and the risk of suicide.[82] The higher rates of PTSD and cumulative traumatic stress exposure involving ambulance officers means that they are a group with a greater risk of suicide and both awareness of these risks and an intervention strategy is required by management.

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[82] LeBouthillier, D. M., McMillan, K. A., Thibodeau, M. A., & Asmundson, G. J. (2015). Types and number of traumas associated with suicidal ideation and suicide attempts in PTSD: findings from a U.S. nationally representative sample. *J Trauma Stress, 28*(3), 183-190.

[83] Pietrzak, R. H., Goldstein, R. B., Southwick, S. M., & Grant, B. F. (2011). Prevalence and Axis I comorbidity of full and partial posttraumatic stress disorder in the United States: results from Wave 2 of the National Epidemiologic Survey on Alcohol and Related Conditions. *J Anxiety Disord, 25*(3), 456-465.

[84] Lopez-Castroman, J., Jaussent, I., Beziat, S., Guillaume, S., Baca-Garcia, E., Olie, E., & Courtet, P. (2015). Posttraumatic Stress Disorder following childhood abuse increases the severity of suicide attempts. *J Affect Disord, 170*, 7-14.

[85] McFarlane, A. C. (2004). The contribution of epidemiology to the study of traumatic stress. *Soc Psychiatry Psychiatr Epidemiol, 39*(11), 874-882.

[86] Sareen, J., Houlahan, T., Cox, B. J., & Asmundson, G. J. (2005). Anxiety disorders associated with suicidal ideation and suicide attempts in the National Comorbidity Survey. *J Nerv Ment Dis, 193*(7), 450-454.

[87] Marshall, R. D., Olfson, M., Hellman, F., Blanco, C., Guardino, M., & Struening, E. L. (2001). Comorbidity, impairment, and suicidality in subthreshold PTSD. *Am J Psychiatry, 158*(9), 1467-1473.

2.10 Suicidal Ideation and Attempts in the Emergency Services

No study has been done comparing suicidality in an Australian ambulance service with the Australian population, although there are Australian studies of suicide in police. The one systematic review of suicidality in emergency personnel examined 63 quantitative studies of first responders.[88] A number of methodological weaknesses were identified which limited the conclusions that could be made. However, there was a general conclusion that there were significantly elevated risks for suicide amongst first responders. The authors noted that there was a lack of data about emergency medicine therapists and paramedics in contrast to the other emergency services. The specific risks and protective correlates were considered. These included multiple high-risk roles, role transitions including fewer years of service, and smaller departments due to the lack of mental health resources. Posttraumatic stress disorder was noted to be "*especially important".* The role of job dissatisfaction and burnout predicted suicidal ideation but this effect generally disappeared when statistically adjusting for depression, highlighting the importance of assessing psychiatric symptoms.[89]

There are a number of studies of police suicides including in Australia.[55] [90] [91] [92] Psychiatric illness was often manifest indirectly at the time of their death with one study finding that 31.5% had work performance issues and 23% were under investigation at the time of their death.[92] This highlights that a proxy of psychiatric difficulties that contributed to suicide may have been indirectly manifest by work performance issues. This emphasises the importance of considering the mental health of emergency service personnel who are subject to performance review. Another study utilising an unusual methodology of analysing web articles indicated that "*work associated legal problems were implicated in about 13% of police suicides in 2012*".[93]

A study of a national sample of operational Norwegian ambulance personnel examined the prevalence of suicidal ideation and attempts.[94] Amongst the 1,180 respondents, the lifetime prevalence of feelings that life was not worth living was 28%, 10.4% had been seriously considering suicide, and 3.1% had made a suicide attempt. These rates

[88] Stanley, I. H., Hom, M. A., & Joiner, T. E. (2016). A systematic review of suicidal thoughts and behaviors among police officers, firefighters, EMTs, and paramedics. *Clin Psychol Rev, 44*, 25-44.

[89] Berg, A. M., Hem, E., Lau, B., Loeb, M., & Ekeberg, O. (2003). Suicidal ideation and attempts in Norwegian police. *Suicide Life Threat Behav, 33*(3), 302-312.

[90] Cantor et al. (1995) A historical survey of police suicide in Queensland, Australia, 1843-1992. *Suicide and Life Threatening Behaviour*, 25:499-508.

[91] Chae & Boyle. (2013) Police suicide: prevalence, risk, and protective factors. *Policing: An international journal of police strategies and management*, 36:91-118.

[92] Barron, S. (2010). Police officer suicide within the New South Wales Police Force from 1999 to 2008. *Police Practice and Research: An International Journal 11*(4), 371-382.

[93] O'Hara, A. F., & Violanti, J. M. (2009). Police suicide--a Web surveillance of national data. *Int J Emerg Ment Health, 11*(1), 17-23.

[94] Sterud, T., Hem, E., Lau, B., & Ekeberg, O. (2008). Suicidal ideation and suicide attempts in a nationwide sample of operational Norwegian ambulance personnel. *J Occup Health, 50*(5), 406-414.

are nearly double the rates of suicidal thoughts and attempts observed in the general population in Australia, an indication of the magnitude of these concerning symptoms. The predictors of suicidal ideation that were found to be independently associated were job-related emotional exhaustion, bullying at work, younger age, not married/cohabiting, depression symptoms, low self-esteem, and personality/reality weakness. In general, these rates were similar to Norwegian physicians but higher than police.[94]

A study of a nationwide convenience sample of fire officers in the USA found that a career prevalence of suicidal ideation was 46.8%, plans 19.2%, attempts 15.5% and non-suicidal injury 16.4%. As this was not a representative sample, it is difficult to identify the prevalence of these phenomena but it was suggestive of significant risks of such phenomena in another emergency population.[95] Importantly, a history of having responded to a suicide attempt or death by suicide was a significant risk factor. This effect of having witnessed suicide as increasing the probability of suicidal ideation was also identified in a study of US veterans.[96] This observation is important as such exposures of ambulance officers which is a regular part of their duties is likely to increase their risks of suicidal ideation. This specific phenomenon has not been explored in ambulance officers. This highlights how exposure to suicide of members of the public in the ambulance service may break down some of the taboos about death and the ending of life by suicide.

2.11 Foreseeable Risk and Need for Evidence-based Interventions

On the basis of the available evidence, ambulance officers in the St John's Ambulance in Western Australia are at particular risk of trauma related psychiatric disorders because of the rates of trauma exposure of these individuals. Predictably there will be greater rates of suicidality that carry a significant risk of completed suicide. As a consequence, it is important that a strategy exists for identifying and managing those at risk in emergency settings such as the Western Australian ambulance service.[97] Strategies and specific guidelines for Australia, endorsed by the NHMRC, have also been published for the diagnosis and treatment of trauma-related disorders that should inform the provision of prevention and treatment services in the emergency services.[98] This document has a specific section highlighting the predictable risk of mental disorder in emergency service and military personnel.

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[95] Stanley, I. H., Hom, M. A., Hagan, C. R., & Joiner, T. E. (2015). Career prevalence and correlates of suicidal thoughts and behaviors among firefighters. *J Affect Disord, 187*, 163-171.

[96] Cerel, J., van de Venne, J. G., Moore, M. M., Maple, M. J., Flaherty, C., & Brown, M. M. (2015). Veteran exposure to suicide: Prevalence and correlates. *J Affect Disord, 179*, 82-87.

[97] McFarlane, A. C., & Bryant, R. A. (2007). Post-traumatic stress disorder in occupational settings: anticipating and managing the risk. *Occup Med (Lond), 57*(6), 404-410.

[98] The Australian Centre for Posttraumatic Mental Health. (2007). The Australian Guidelines for the Treatment of Adults with Acute Stress Disorder and Posttraumatic Stress Disorder. *Melbourne, Victoria: ACPMH*.

Above and beyond the general risks and methods of managing posttraumatic stress disorder, specific recommendations were about the emergency services. It stated, *"The particular challenge for these groups of people is to implement treatment as early as possible. Using the principles of secondary prevention, this minimises the development of a series of patterns of adaptation that, in themselves, can present a significant disadvantage. The systems of care that ensure early identification, such as screening and addressing stigmatisation in the workplace, are of particular importance … a significant experience in dealing with these particular groups is also an important matter for clinicians because understanding the specific culture of these organisations can be central to the development of a positive therapeutic relationship with the ASD or PTSD sufferer"* (p. 142).[98]

These guidelines particularly set out how alcohol abuse, inter-personal conflict and numbing are frequent presentations. Furthermore, it specifically highlights that *"the individual's difficulties may become manifest as increasing conflict with senior personnel over a variety of operational and disciplinary issues"*.

The design of the clinical services and the nature of the services required are beyond the scope of this review. Extensive high quality reviews by organisations such as the Institute of Medicine are available and can be used to inform the development of evidence based services.[99]

2.12 Conclusion

The particular occupational hazards arising from traumatic incidents that ambulance officers attend, means this workforce carries a foreseeable risk of psychological injury. The body of literature points to the probability of developing posttraumatic stress disorder and the risk arises from the cumulative exposure across the course of a career. This points to the need to manage the ambulance service workforce across the lifespan of ambulance officers. Particularly with increasing age, the probability of physical injuries and other medical comorbidities are further factors that need to be taken into account. The interaction between physical and psychological comorbidities can have an important impact on the course and recovery from both physical and psychological injuries.

The traumatic stressors in an ambulance officer's career do not sit in isolation. Other occupational stresses including shift work, fatigue, and a paramilitary culture that at times can foster bullying are important factors to also take into account. These occupational stressors tend to be a focus of concern and complaint, particularly if an officer is not coping optimally.

Whilst suicidal ideation and attempted suicide occur in only a small minority of those with psychiatric disorders, as many as 10% of an ambulance service may have seriously

[99] Erdtmann, F. (2014). Preventing Psychological Disorders in Service Members and Their Families: An Assessment of Programs. *Military Medicine, 179*(11), 1173-1175.

considered suicide. Whilst the rates of completed suicide are much lower, it highlights the importance of having preventative programs in this occupational setting.

Suicide inevitably arises as a complex matrix of individual risk factors, interpersonal and social stressors that may not be work related, as well as exposure to traumatic stress in the occupational environment. Independent of their cause, psychiatric disorders in the workplace can be exacerbated significantly by further and ongoing exposure to traumatic stressors. Hence, there is a foreseeable risk to ambulance employees with emerging psychiatric symptoms of continued and ongoing trauma exposures. Managing this risk is an important responsibility of ambulance services.

It is difficult to draw conclusions when comparing the rates of suicide within an emergency service such as the ambulance service and the general population because of the healthy worker effect. Hence, the central strategy is to identify the risks and hazards that exist within the workforce that may have contributed to the risks of suicide so that these can be mitigated by public health as well as individual interventions.

3 Chief Psychiatrist Review: St John Ambulance Paramedic and Volunteer Suspected Suicides

This chapter first provides a summary of the Chief Psychiatrist Review Report, followed by the Panel's views of the Report and recommendations. The Panel provided the Chief Psychiatrist with an opportunity to review a draft version of this chapter, and this final version takes into account his response.

3.1 Summary of the Report

The terms of reference of the Review conducted by the Chief Psychiatrist were to consider the factors contributing to five suspected suicides of St John Paramedics and Volunteers which occurred between 21 December 2013 and 20 March 2015. In doing so, the Chief Psychiatrist was tasked to specifically consider the requirements of the individuals' roles as a 'first responder' – Paramedic or Ambulance Volunteer – which may have contributed to their deaths. Individual, cohort or systemic factors were to be considered in the Review.

The Chief Psychiatrist was to make findings and any appropriate recommendations that may assist St John to determine the best approach to deal with the emotional and psychological impact of work and non-work stresses that impact the wellbeing of their staff and volunteers.

The Review was to include:

- Examination of any available health records with consent from the surviving next of kin;
- Interviews with appropriate third parties, which may include surviving family members or work colleagues, among others;
- Examination of information available to St John relating to each case. This includes although is not restricted to, the ambulance case history of each first responder;
- Examination of St John policies or programs, so far as their relevance to the comprehensive understanding of the individual or cohort of cases at the time of their deaths;
- The Chief Psychiatrist may consider any relevant literature, reports, expert commentary or jurisdictional data relating to suicide and first responders.

The Review did not seek to evaluate the existing wellbeing and support services provided by St John, though the Chief Psychiatrist's review team (the Reviewers) did make a number of recommendations in this area.

The Reviewers considered the 'work and non-work stresses' that may have contributed to the deaths by suicide of the individuals and each death was examined against the following factors:

- Factors associated with the role as 'first responder' (eg critical incident trauma, exposure to abuse and threats/actual violence, shift work);
- Workplace factors (eg Interpersonal conflict, bullying, harassment, level of peer support, level of supervisor support);
- Organisational factors (eg level of organisational support, blame culture, performance management, professional development);
- Social factors (eg family conflict, relationship difficulties, level of social support) ;
- Individual factors (eg personality traits, coping strategies, level of resilience, mental disorder).

The Reviewers concluded in all cases, individual factors such as personality traits, coping strategies and mental health problems (including in some cases diagnosed mental illness) were major contributory factors in their deaths. The Reviewers "*found little evidence that exposure to 'critical incidents' in their roles as first responders was a key factor in the deaths (p5)*.

3.1.1 Chief Psychiatrist Recommendations

The Reviewers made seven recommendations, providing discussion and context for each in the Report:

1. It is recommended that St John work in close partnership with staff, volunteers and their families, to review their wellbeing and support services to increase 'ownership' and address the challenges in providing such services.

2. It is recommended that St John broaden its response to the impact of suicide and other forms of traumatic death amongst its staff and volunteers by providing proactive, ongoing support focused on the work group, which recognises and builds upon the group's coping strategies.

3. It is recommended that St John investigate how to better respond to the management of conflict in the workplace, including in cases of ongoing serious conflict, using an independent skilled mediator.

4. It is recommended that St John review its Performance Management process with a view to providing clear guidance on the conditions under which:
    - The process may need to be amended or suspended;
    - Expert psychological advice should be sought
    - An independent person be appointed.

5. It is recommended that St John in partnership with WA Country Health Service undertake a detailed review of the ambulance service in the Northern Goldfields to determine the most effective service delivery model for this region.

6. It is recommended that St John review its volunteer recruitment process to include an assessment by regional services (possibly including reference checks, interviews and on-the-job experience) with delegation of the final decision for acceptance to regional services.

7. It is recommended that St John undertake the development of an Employee Engagement Strategy and Action Plan.

The Report was provided to the Panel on 15 January 2016 and St John's response to the Report was provided to the Panel on 26 February 2016. The Panel subsequently met with the Chief Psychiatrist and the Review team on 8 March 2016 to discuss the Review methodology and report contents.

Both the written report and the subsequent discussion inform the Panel's comments provided here.

3.2 Independent Oversight Panel's Considered Comments

This section provides a summary of the views of the Panel of the Chief Psychiatrist's report.

On face value the report provides an adequate overview of the information gathered by the Reviewers in the interviews with Next of Kin and workplace colleagues. It gives a sense of the pervasive and systemic workplace and organisational issues which impact significantly on the St John workforce. These findings concur with the themes arising in consultation conducted by the Panel.

3.2.1 Limited Terms of Reference

The terms of reference for the Review were specific and the Reviewers felt perhaps did not reflect the breadth and depth of the issue. The Reviewers did say they expected the broader remit of the Panel would examine further issues, and through the course of the verbal briefing the Panel was able to ascertain the issues which were not explicitly addressed in their report.

It is assumed by the Panel that as the terms of reference tasked the Chief Psychiatrist to specifically consider the requirements of the 'first-responder' role this is why the report did not comprehensively assess the contribution other factors may have had on the deaths by suicide of the individuals.

3.2.2 Limited Literature Review

It is the Panel's view that a key weakness of the Report lies in the limited reference to contemporary literature on mental health issues in the emergency services workforce.

In terms of mental health issues, the Report focussed only on rates of suicide in the paramedic workforce, stating that the '*general belief that ambulance workers have*

higher rates of suicide than other comparable occupations' was not able to be conclusively supported or negated due to lack of reliable studies (p12).

It appeared not to consider a number of studies which provide a comprehensive assessment of the psychological risk and rates of disorder in the emergency service workforce.

The limited literature review in the opinion of the IOP meant that the Review did not fully address the context of the occupational framework and possible contributions to suicidal risks of the cases under review. Given the body of literature available on the mental health of emergency service workers and the risk factors identified from these occupational settings that increase the probability of disorder, the Panel is of the view this was a significant omission.

3.2.3 Report not Fully Reflective of all Information Collected

In the course of their review the Reviewers interviewed nine Next of Kin of the deceased, as well as colleagues of the deceased who were identified by St John and a number of other staff and volunteers who self-nominated (21 in total). The Reviewers also accessed health records for some of the individual cases[100] and excerpts from St John personnel files for each individual. Additionally, the Senior Manager of Wellbeing and Support Services was interviewed.

Valuable information was collected from family members and colleagues who provided important contextual information about the experiences of the individual's antecedent to their suicides.

It was acknowledged by the Reviewers that in redacting all personal information about the individual cases, the report findings may have lost strength. It was also noted by the Reviewers that it was challenging to discuss specific contributing factors in the report without identifying the individual cases to which they refer.

3.3 Independent Oversight Panel Considered Comments

The Reviewers acknowledged there was complex interplay between work and non-work sources of stress in each of the five paramedics/volunteers lives that may have contributed to the person's death. These were identified as:

- Emergency worker (first responder) role;
- Workplace factors;
- Organisational factors;
- Social factors;
- Individual factors.

[100] Access to an individual's health record was undertaken subject to permission received from the Next of Kin.

While the Reviewers found limited evidence that exposure to critical incidents in their roles was a key factor in the deaths of the five paramedics/volunteers, they did raise the issue of cumulative stress and the challenges associated with the nature of the job.

As evidenced in the Literature Review (Chapter 2), the Panel notes that there is a significant body of literature that demonstrates the linkage between critical incidents, cumulative stress and psychiatric disorders.

In light of the Chief Psychiatrist's Review, the Panel has considered the following items that, while not addressed in the report, have raised further questions including:

- Was St John's post intervention response in managing the resultant trauma in the workplace following the suicides adequate? The Reviewers found a significant level of distress and in some cases dysfunction in the workplaces that they visited. Submissions to the Panel have also indicated that the workplaces and individuals affected have remained fractured and distressed months after the event. As well as being critical to the workforce feeling supported by the organisation, this is an important occupational safety and health obligation.

- What was the contribution of workplace and organisational factors in each case, that is, what the antecedent incidents were leading up to the each person's death that contributed to the stress felt by the individuals? The Reviewers have touched on this issue through Recommendation 3 (management of conflict in the workplace) and Recommendation 4 (performance management), but have not expanded on specific workplace and organisational factors. The Panel, through the submission process, have identified in a least two of the individual cases, there was evidence of significant occupational and workplace stressors faced by each individual.

- In the applicable cases, did the decision by St John to engage volunteers or paramedics with a known pre-existing mental illness indicate a lack of appreciation of the impact of 'first responder' roles, and the impact of exposure to trauma on people with psychiatric disorder?

- Did the lack of transition to retirement planning for employees who realistically may have not been capable of performing at optimum levels in on-road roles, enhance the psychological stressors on individuals?

- Did the lack of post-employment follow up for employees with known mental health issues (that manifested during the period of employment) impact on the psychological stress of the individuals?

In the opinion of the Panel, the adequacy of St John's existing processes and infrastructure to identify and manage employees or volunteers with psychiatric issues needs to be reviewed. This will be further discussed in Chapters 6 and 7.

3.4 St John Response to the Chief Psychiatrist's Report

St John provided the Panel with its written response to the Chief Psychiatrist's Report in which it outlined views on each of the recommendations.

In summary, St John contend the small sample size and limited scope of the Review did not provide a realistic picture of the effectiveness of services, strategies and policies in place. It did agree with all bar two of the recommendations made by the Chief Psychiatrist but noted in each case that had the remit of the Review been broader the Chief Psychiatrist would have had the evidence to see that recommendations were already addressed either fully, or in part.

One recommendation St John did not agree with related to regional involvement in the recruitment of volunteers, arguing again that evidence exists outside the review scope. The second related to a review of the Northern Goldfields service model, with St John arguing it and the WA Country Health Service already have strategies in place to improve this.

It is the Panel's considered view that whilst the St John response to the Chief Psychiatrist's recommendation may represent the management view, the lived experience of operational staff may be quite different. This conclusion is reinforced by the consultations and findings of the Panel, the emergent themes of which are explored in Chapter 6.

3.5 Summary

Overall, the Panel is of the view that the Report of the Chief Psychiatrist provides valuable insight and recommendations that if acted upon, will contribute to an improvement in wellbeing support for the St John workforce.

The Panel is of the view however, that the Report could have been strengthened by more detailed reference to contemporary literature exploring psychological risks in the emergency services workforce.

Likewise, further exploration and articulation of the workplace and organisational factors experienced by the individuals who later took their lives may have provided more strength to the findings.

Had both of these items been more adequately covered, it would have provided St John with more context and detail from which to consider changes required to policy, procedures and practices.

4 Phoenix Australia – St John Ambulance Review of Workplace Mental Health Issues

This chapter first provides a summary of the Phoenix Australia Review Report, followed by the Panel's views of the Report and recommendations.

4.1 Summary of the Report

The Phoenix Australia Review was the second key report for the Panel's consideration. St John commissioned Phoenix Australia – Centre for Posttraumatic Mental Health (University of Melbourne) to undertake a review of their current approach to identifying and managing psychological risks for all employees in the workplace, including an assessment of the current approach against best practice.

The scope of the Review was to cover the psychological risks that exist for St John employees and volunteers, the current supports and systems that St John has in place to manage psychological wellbeing, the accessibility and effectiveness of current supports and systems, and to recommend improvements and/or alternative approaches that are required for best practice.

The Review "*St John Ambulance Review of Workplace Mental Health Issues*" was finalised in February 2016. The Review identified a number of key findings in relation to psychological risks and the impact on St John employees and volunteers, and the accessibility and effectiveness of current St John supports and systems.

4.1.1 Phoenix Recommendations

The Phoenix Australia Review provided eleven (11) recommendations in the areas of a) systems and documentation (Recommendations 1 and 2); b) training, education and support (Recommendations 3 and 4); c) organisational culture and employee engagement (Recommendation 5); d) wellbeing and support (Recommendations 6, 7 and 8); e) community and country paramedics (Recommendations 9 and 10); and f) alternative approaches (Recommendation 11). The recommendations are as follows:

Recommendation 1
Review Safety and Injury Support Services (SISS) documentation (e.g., risk register, OHS responsibilities) to reflect thorough consideration of psychological as well as physical risks.

Recommendation 2
Develop an evaluation and continuous improvement framework for managing psychological risks.

Recommendation 3
Engage with mental health professionals (either internal or external) with relevant experience to provide regular and repeated workplace training for managers in how to identify signs and symptoms of stress and how to support their staff.

Recommendation 4
Provide initial and ongoing workplace training and mentoring for managers to ensure development and maintenance of core skill competencies for managing and supervising staff, including how to address staff issues such as bullying in a timely and appropriate manner. To ensure that skills are maintained, refresher training should be offered at least every two years.

Recommendation 5
Undertake a review of organisational culture and employee engagement, including:

5.1 Engage relevant experts to provide specific education and training to staff throughout the organisation on identifying and addressing workplace culture issues including appropriate behaviour in resolving workplace conflict, with a particular focus on bullying; and
5.2 Arrange regular staff consultations and communications to raise matters of interest and concern to staff and encourage their input and feedback; and
5.3 Arrange specific communication and consultation strategies for regional staff to ensure region-specific issues are understood and responded to.

Recommendation 6
Employ qualified and experienced mental health practitioner/s on the WB&S team.

Recommendation 7
Modify the content of mental health literacy and psychological first aid to be consistent with best practice approaches to these programs. Implement these programs across the organisation to ensure that staff are supported and their wellbeing monitored in an ongoing way, but particularly after a potentially traumatic event.

Recommendation 8
Formalise the existing avenues of support into a wellbeing and support model that provides St John staff with clear guidance on the different levels of support that are available to them, based on preference and need. Ideally, a dedicated peer support team would be a part of the wellbeing and support model.

Recommendation 9
Provide initial and ongoing workplace training for paramedics who work with volunteers to ensure development and maintenance of core skill competencies for managing and supervising volunteers. To ensure that skills are maintained, refresher training should be offered at least every two years.

Recommendation 10
Undertake a review of community and country paramedic processes to ensure recruitment, role clarity, training and support processes adequately address the challenges of working as a country or community paramedic.

Recommendation 11
Implement regular mental health screening of staff wellbeing combined with tailored self-care information.

11.1 On an annual basis, staff undertake an anonymous online mental health screen that provides feedback on wellbeing, guidance on self-care, and recommendation for appropriate level of support and professional care, where required; and

11.2 On a two-yearly basis, staff have a face-to-face or telephone mental health screen with a mental health practitioner. On the basis of the results, the mental health practitioner would provide feedback to the employee and make recommendations for ongoing self-care and/or mental health treatment if required.

The Report was provided to the Panel on 2 March 2016. The Panel subsequently met with Tony Ahern, CEO, St John on the 8 March 2016 to discuss the organisation's response to the Report.

4.1.2 Limitations of the Review

The Review authors acknowledged a number of limitations with the Review method in considering organisation-wide responses. Specifically, the initial consultation and findings reported from the consultation sessions were not intended by the authors to be a representative sample of St John staff and volunteers; rather this process was to provide a convenience sample to assist with the development of the organisation-wide survey.

The authors also note that findings may be subject to the potential for bias in those who chose to participate in an open survey.

Aligned to this, the Panel has considered that the recommendations from the *Phoenix Australia Review* are based on a workplace climate survey, and not a systematic assessment of the mental health state of the workforce. That is, the Review was limited in that the organisation-wide survey was a self-perception survey based on an individual's perceived risk and attributions and not a systematic assessment of the factors and stressors contributing to the overall mental health state of the workforce. The Panel acknowledges the authors had a limited Terms of Reference, with the Review having a specific focus on the current supports and systems that St John has in place to manage the psychological well-being, the accessibility and effectiveness of these supports and systems, and improvements to promote best practice. It did not provide a systematic mental health survey of the workforce.

The Panel notes that despite the limitations of a non-representative sample, the findings should alert St John to the probability of the prevalence in their workforce of psychological risks, and it would be prudent to have a systematic response. The Panel has considered the *Phoenix Australia Review* findings and recommendations in its own deliberations.

It should also be noted that the *Phoenix Australia Review* was commissioned prior to the commencement of the Independent Oversight Panel.

4.2 Independent Oversight Panel Considered Comments

The *Phoenix Australia Review* acknowledges that St John employees are inevitably exposed to a range of psychological risks during the normal course of their work and identified that the potential risks included: shift work; potentially traumatic events; working in a high demand, low control environment; and for some, working in a geographically isolated area.

However, the Review identified that the "*the most commonly reported and highest rated sources of stress for employees were not issues inherent in the role, but problems that can be more readily addressed: bullying and perceived lack of understanding and support from management."(*p 24)

Specifically, the authors commented on the perception of bullying in the workforce:

> *Putting aside the issue of whether incidents of perceived bullying fulfil legal definitions of the term, bullying was reported between paramedics, between paramedics and State Operations Centre (SOC), between paramedics and volunteers, between staff and middle management (including 'upward bullying' whereby management reported being bullied by staff as well as reports of staff being bullied by management) and between 'corporate St John' and staff. Comment was made that there is a culture of bullying at St John. (p 17).*

The Report had a strong focus on the perception of bullying in the workplace as a key psychological stressor for the workforce. The Panel notes that the Report did not expand further on other potential psychological stressors referred to above. Additionally, the authors did not review or address the cumulative effect of exposure to trauma which should be considered as a contributing effect to employee psychological stress.

In respect to the support programs provided by St John's Wellbeing and Support services, the authors noted that there was variable feedback with a tendency to polarised views. The authors noted: *"There were positive comments about the responsiveness of the team, the support provided and the training program. On the other hand, there were many more negative comments on the same issues, including complains of no follow-up after staff had initiated contact seeking support (p39)".* The

Panel concurs with this view based on feedback and information provided as part of the investigations.

The authors further reported that: "*Scores on the Psychosocial Safety Climate survey indicated that St John employees do not perceive that senior management gives high priority to policies, practices and procedures for the protection of staff psychological health and safety. We do not assume that this perception is accurate, but do believe that the finding highlights the need for improved communication between St John management and staff to demonstrate that staff opinions are valued and their wellbeing priorities. (p43)".* The Panel concurs with the authors' views of the requirement of management to further strengthen communication with employees.

An important aspect the *Phoenix Australia Review* highlighted was concerns by the authors that current approaches of the Wellbeing and Support Service to mental health literacy, psychological first aid and the organisation's program for developing the capacity and function of peer support amongst employees was not grounded in evidence-based best practice. The Panel concurs with this finding and the requirement for St John to undertake more systematic and rigorous evaluation of wellbeing and support programs with the support of qualified and experienced mental health practitioners in this area.

4.3 St John Response to the Phoenix Review

St John provided the Panel with a response to the *Phoenix Australia Review* in which it outlined views of each of the recommendations. In summary, St John agrees with all recommendations and has commenced work to progress action.

In discussion, St John management has raised a concern with conflicting expert advice received in relation to mental health literacy and psychological first aid programs through the review and external providers, but believes that the appointment of specific mental health expertise will assist the organisation progress this initiative.

4.4 Conclusion

Notwithstanding its noted limitations, the *Phoenix Australia Review* does provide appropriate recommendations with which the Panel concurs.

The Panel's own broader Terms of Reference have allowed a broader review of the issues and challenges facing St John, and it is on this basis that the *Phoenix Australia Review's* recommendations and issues raised have been further expanded in this Report.

5 The Toll of Trauma on Western Australian Emergency Staff and Volunteers Report

In addition to the two reports discussed in Chapters 3 and 4, the Panel also took the opportunity to consider a recent review relating to emergency services and the impact of trauma on first responders in Western Australia – *The Toll of Trauma on Western Australian Emergency Staff and Volunteers*[101] (the Report).

As with the previous two Chapters, this Chapter will contain a short summary of the Report followed by the Panel's views of the Report and recommendations.

5.1 Summary of the Report

This Parliamentary Inquiry conducted by the Community Development and Justice Standing Committee extensively reviewed the responses by first responder agencies to the experience of trauma by employees and volunteers.

The Terms of Reference of the Inquiry focused on State Government workers and volunteers who work with, or under the supervision of, State Government agencies which are involved in emergency responses. The Inquiry considered:

- whether existing agency responses adequately address the trauma experienced by staff and volunteers during and after declared natural disasters which have occurred since 2001;
- the barriers to those suffering trauma from accessing available assistance services; and
- the measures to mitigate any health impacts from trauma to those State Government workers and volunteers who responded to a declared disaster.

Whilst recognising that St John is not a State Government agency, the inclusion of paramedics as first responders in Western Australia is critical. St John's Clinical Services Director participated in a hearing although the organisation did not make a written submission to the Inquiry.

The *Toll of Trauma Report* was released in September 2012 and identified 23 recommendations to improve the process and management of psychosocial wellbeing of staff and volunteers across emergency response agencies.

[101] Parliament of Western Australia (2012). *The toll of trauma on Western Australian emergency staff and volunteers. Report No 10*: Legislative Assembly, Parliament of Western Australia. Available at: http://www.parliament.wa.gov.au/parliament/commit.nsf/(Report+Lookup+by+Com+ID)/F2C31700C3F0C38A48257A8600065F4D/$file/CDJSC-Toll+of+Trauma-+Final.pdf

5.2 Independent Oversight Panel Considered Comments of the Review

The Report identified that Western Australia's first responder agencies had in place processes for dealing with the trauma of emergency staff. However, at the time of the Report, the Committee noted that these responses were less advanced than in other jurisdictions in Australia. They also identified that this left first responder agencies derelict in their duties to some of their staff and volunteers exposed to traumatic incidents.

The Committee stated that it was evident that the day-to-day activities of the State's police officers, firefighters and ambulance paramedics often created greater trauma than that flowing from specific disasters. This statement reflects the Panel's position on the impact of cumulative stress as a result of day to day activities by ambulance personnel.

The Report highlighted two significant legal precedents (Hegarty v Queensland Ambulance Service [2007] QCA 366 and State of New South Wales v Doherty [2010] NSWCA 225) that, at the time, illustrated that agencies providing evidence at the enquiry had limited knowledge of the implications to their health and safety programs. The Committee found that:

> "*These cases suggest that if there are no signs of prior history or indicators of illness, that it may be sufficient to satisfy an employer's duty of care to ensure the availability of a free and confidential counselling service. However, the standard is likely to be considerably higher where a pre-existing vulnerability of the employee is known or where there are clear signs further monitoring or testing is warranted.*
>
> *The Doherty case unambiguously finds that returning an employee to the same nature of work that caused the initial trauma will almost certainly result in a finding that the employer had breached their duty of care. It also highlights the need for employers to be able to track the traumatic incidents faced by all of their staff. (p 9)*

Similarly, the Committee identified that there seemed to be limited recognition for first responder agencies of the implications of the national harmonised legislation *Work Health and Safety Act 2011 (Cwth)* at the time of the enquiry, "*which expands the definition of 'health' to include psychological health. Although Western Australia is the only State yet to introduce this legislation to Parliament, the decision to have uniform legislation was agreed to by the Council of Australian Governments in July 2008*." (page ii)

The Panel notes that these legal precedents have implications in the way first responder agencies should not only record and track an employee's involvement in critical incidents, but also highlights the agency's duty of care where an employee is known to have symptoms arising from involvement in critical incidents or day to day stressors and is returned to the workplace.

One of the key recommendations of the Parliamentary Committee was the high priority for first responder services to develop a system for tracking their staff and the number of traumatic events attended. The Panel did not see evidence from St John that it has an adequate **tracking** system in place to address this requirement. The issue of tracking of critical incidents for staff is addressed further in Chapters 6 and 7.

In respect to rates of post-traumatic stress disorder (PTSD) within first responders, the Parliamentary Committee identified that research had shown that between 10-30% of first responders are in danger of developing PTSD as a result of attending a disaster or critical incident. Similar figures have been identified in the Panel's recent review of the literature in Chapter 2 highlighting this issue and the potential impact on first responders.

The Parliamentary Committee raised two key barriers that may inhibit staff from utilising the agencies' processes for dealing with both critical incidents and day to day stressors.

> *The first barrier is the prevailing culture of the agency (as most first responder agencies remain male-dominated). The second barrier is trust that staff have that the information they provide will remain confidential and not be used against them when it comes to future activities, such as promotion.*
>
> *The Committee heard that when the culture of an agency changes, welfare services are more readily accepted. For instance, the Queensland Ambulance Service told the Committee that younger recruits coming to the service from a university program was one of the reasons behind a 135% increase in officers with less than five years' service using the counselling and peer support programs. The issue of trust was largely found where there is a perception of a 'them' and 'us' attitude within an agency. (page v)*

The Panel concurs with these findings, with further discussion of these issues in relation to St John raised in Chapters 6 and 7.

5.3 St John's Response to the Toll of Trauma Report

The Panel made the assumption that because St John is not a state government agency it was not explicitly named in a number of the recommendations and that this is one reason why the organisation did not systematically address the recommendations. The Panel notes that St John could have addressed a number of the recommendations, regardless of their status, and doing so may have resulted in an improved wellbeing and support service.

5.4 Conclusion

The Panel acknowledges this significant Report and recommendations to advance the provision and evidence-based structure of wellbeing and support services to first responders, including volunteers, in Western Australia.

In hearings attended by representatives of WAPOL and DFES, it was evident to the Panel that both these government departments had progressed an implementation process to address the Committee's concerns and recommendations. These agencies discussed their willingness to engage with St John to share resources and expertise and the Panel assumes that St John would be open to this. While they acknowledged a level of engagement with St John, both agency representatives identified that there are significant opportunities to extend engagement in the area of employee well-being and support across the three main first responder groups and would welcome this opportunity.

6 Summary of Observations from Submissions and Private Hearings

6.1 Introduction

This section summarises the key themes emerging from the written submissions received, and private hearings held by the Panel. Where relevant, this summary is followed by a brief comment by the Panel in order to provide context or other important perspective.

The themes arising from these consultations have been carefully considered by the Panel, and in conjunction with the various Reports summarised in earlier Chapters, inform the Panel's discussion, findings and recommendations in Chapter 7.

At this point it is important to emphasise the subjective nature of the information in this Chapter. What appears here are the opinions and views put forward by individuals who have an association with St John. The Panel has not attempted to confirm or negate the objectivity of the comments made. This Chapter is simply a summary of the issues raised.

In terms of raw numbers, the St John staff who participated in the Panel's Review represent a small minority of the total St John workforce, although a larger minority of the frontline workforce (those who receive emergency calls and attend emergency call-outs). It is impossible to state categorically that the views presented are shared by their colleagues. Some of the issues raised were of such significance that even if only one or two people had experienced it, it was believed by the Panel still severe enough to be taken seriously.

The Panel has been careful to identify and avoid hearsay – where an individual has reflected on an experience of another individual, as distinct from an individual's reflection of their own personal experience.

Issues raised in consultations that clearly fell outside the terms of reference of the Panel have not been referenced in this Report.

6.1.1 Profile and nature of the submissions

A total of approximately 100 staff voices contributed to the Review, providing valuable insights into the experiences of the St John workforce. Sixty seven written submissions were received, over 20 private hearings were conducted and a range of other more informal consultations occurred at the State Operations Centre, St John State Conference and on visits to a metropolitan depot and two metropolitan hospital sites.

Of the St John operational workforce consulted, approximately 65% were male and 35% female and length of service ranged from less than two years to multiple decades.

Approximately one third of respondents indicated they are currently metropolitan-based, one third are country-based and the remaining third did not state their current location. Several respondents indicated they had worked in a variety of roles in both country and metropolitan sites.

The vast majority (approximately 72%) were current employees of St John, followed by volunteers (approximately 11%) and ex-employees (approximately 7%). The remainder of respondents were either not employed by St John (parents, partners) or did not state their employment relationship.

More than half of respondents were in operational on-road paramedic roles. Other roles represented were Patient Transport, administration, station management, area management and the State Operations Centre.

Nine individuals indicated they had received treatment and/or had a current clinical diagnosis relating to depression, anxiety or PTSD. Five of these individuals indicated they had previously had suicidal thoughts and several had in fact, attempted to take their own life by suicide. Of the five, all cited their work environment as being a contributing stressor – the culture, punitive approach and bullying as well as the clinical cases and subsequent lack of wellbeing support.

Submissions ranged from short messages identifying one or two key issues or concerns, through to lengthy, carefully constructed documents describing a multitude of personal experiences. Many were very passionate, articulate and balanced in their wording. The emotion was palpable.

6.1.2 Themes Emerging

The themes emerging from written submissions and private hearings have been categorised as:

- Nature of Ambulance Service Work in the Field (including the State Operations Centre)
- Workforce Wellness
- Organisational Culture
- Operational Management
- Policy and Procedures
- Issues Specific to Country Ambulance Services
- The Wellbeing and Support Model
- Employment Conditions

6.2 Nature of Ambulance Service Work in the Field (including the State Operations Centre)

Almost without fail, submissions spoke of the nature of ambulance service work being traumatic, stressful and challenging. People did talk about harrowing cases they had attended, and were emotive in doing so, but what they were most distressed about was how they were treated by the organisation in the aftermath.

Only a very few submissions made explicit connection between the trauma exposure and their personal mental state. Many however, spoke of needing more down time between jobs and flexibility in accessing their annual leave in order to more effectively self-manage their cumulative exposure to trauma.

Overwhelmingly, staff claimed it was organisational factors that were the most stressful to deal with.

6.2.1 Independent Oversight Panel's Preliminary Observations

It is no surprise employees themselves downplayed the effect exposure to trauma had on them. This is supported by evidence. The issue is that first responders expect to deal with the traumatic events – it is what they trained for. Rather, individuals do not expect the administrative and organisational stresses they experience.

The fact trauma exposure is anticipated does not mean it does not have an adverse effect on their health. It is a reason why a self-referral model for wellbeing support will not be successful in isolation to other identification and preventative strategies.

Of concern is that staff request leave and this is either declined or seen to be unreasonable. What appears not to have been considered in these cases was that staff could recognise the cumulative burden of exposure, (even subconsciously), and needed time away from these exposures.

6.3 Workforce Wellness

Issues relating to the profile and monitoring of the workforce in relation to mental health were raised in many submissions.

6.3.1 Screening – Before and During Employment

Several submissions raised the issue of lack of screening pre and during employment at St John, and only limited psychometric testing during the student recruitment process.

Several submissions also recommended mandatory wellbeing checks on long term staff.

6.3.2 Tracking system

The lack of a system to track and monitor cases attended by individual paramedics was raised several times. This means there appears to be no mechanism in place to identify operational staff exposure during employment to stressors.

One submission recalled being advised by a Wellbeing Officer upon making contact after a major incident that the Wellbeing team were not actually notified of the incident but the officer happened to see it on the news app on her phone.

One country officer believed that all remote jobs should, by default, be followed up. A further submission suggested a system should be instigated where, after so many priority one callouts or after every 350-400 call outs, on road staff are visited on road for a wellbeing and fatigue check, noting that a quantifiable tool needs to be used.

This issue is explored further in the Wellbeing and Support model section below in terms of the apparent haphazard nature of follow up contact to paramedics and communications officers.

6.3.3 Impact of stress and mental illness on families

Several submissions, including from parents in law and partners of paramedics, talked about the impact of the job on a paramedic's family and the need for family briefings and support.

It was suggested that the partners of volunteers be provided education and invited to be part of the wellbeing service as additional support for their partners and themselves.

6.3.4 Independent Oversight Panel's Preliminary Observations

An improvement in St John's understanding of the psychological risk and status of its workforce is critical in order for it to provide the appropriate evidence-based wellbeing support in terms of identification, prevention and access to treatment. A tracking system would appear to be integral to this.

6.4 Organisational Culture – Bullying, Punitive and Disciplinary

All submissions and hearings gave examples symptomatic of an unhealthy organisational culture. This ranged from perceived managerial bullying, to no organisational contact to a paramedic following the suicide of their ambulance partner. Paramedics reported feeling undervalued, unsupported and scared to give constructive criticism in fear of losing their job.

There is a perception that management's main interest lies in statistics rather than outcomes.

The many examples provided in the submissions and hearings illustrate 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.

There were many examples provided in the submissions, and in the interest of maintaining anonymity, just a few are summarised here:

- A paramedic was approached in person in a public place by a manager to explain a five minute delay for a priority 2 call. The paramedic reported feeling that this could have been resolved quickly with a phone call and that by making a scene about it either the manager wanted to exert his power or was under instruction to do so.
- A manager visiting a paramedic's house to check he was sick and not feigning illness.
- The reported use of abusive language and or defamatory language by some manager(s).
- Soon after experiencing an assault by a patient, a paramedic was questioned by their manager about whether the paramedic could shower, change clothes and complete incident paperwork at another time.
- A staff member was made aware by a regional manager that despite being the most highly qualified and experienced person for a role, there was interference by a more senior manager to prevent them being appointed.
- Despite only ever receiving positive annual performance reviews, an employee's annual pay increment was withheld with an explanation only provided several months later once the employee had requested this a number of times.
- Reports of junior officers being asked by managers to keep logs on senior paramedics of behaviour they deem inappropriate and forward that information.
- A country officer reported being stood down for a mental health assessment after complaining of a lack of resources. The officer was reinstated after passing the psychiatric tests with none of the resourcing issues raised having been addressed.

There were several cases of paramedic-initiated complaints and clinical incident reports not being resolved in a fair, timely or helpful manner, sometimes being lost or deleted. Paramedics reported being told by a regional manager that those who make reports are viewed as trouble makers.

There is a sense that operational staff do not think they will be supported by the organisation when certain things go wrong. One paramedic reported that the current approach encourages staff to hide small mistakes and not seek support.

There were several reports of individuals raising bullying incidents informally, and when a manager dismissed the claims or failed to respond the individuals did not feel it was worth a formal complaint being made.

Multiple examples were provided of responses to formal complaints taking several months, or not being received at all. Further examples described performance review paperwork or report documentation prepared by managers as being factually incorrect and staff being pressured to sign them or put at risk a positive outcome.

A view provided in several submissions and hearings was that paramedics are tied to St John because of their commitment to their jobs and the community. It is said that employees feel there are few options for alternative employment in this profession in WA and did not want to jeopardise their job with complaints or recommendations. Some submissions identified that because so few will speak up, it has perpetuated a culture of denial of the problem, or taking 'forever' to address issues or only addressing issues when media or other non-staff sources apply pressure.

The vast majority of the received submissions indicated that they had a lack of trust in middle and senior management (area managers, directors, general managers).

There are perceived alignments between individuals in management leading to a perception of a lack of impartiality. There was reference to certain officers receiving privileges and being out of scope for standard policies and procedures. Perceptions seem to persist that there are senior managers who are above reproach and cannot be investigated, despite allegations of bullying or other misconduct against them.

6.4.1 Leadership has a Dismissive Attitude toward the Prevalence of Mental Health Issues in the Workforce

A strong theme emerged from submissions and hearings, of a dismissive attitude amongst some management, toward the prevalence and severity of mental health issues in the paramedic and communications workforce. The perception is that management think the workforce is sensationalising PTSD, and is dismissive of the effect exposure to trauma can have on individuals and their families.

An example provided was that of a paramedic being stood down pending investigation over an alleged incident. The allegation was made known to the paramedic over the phone by the regional manager 24 hours after the paramedic attended a traumatic callout involving a toddler. The officer was directed to not speak to anyone and therefore did not have opportunity for debrief from such a tragic job until over one week later.

6.4.2 Employee Communication and Engagement

Submissions gave many examples which illustrate lack of communication from management and disconnect between management and operations staff.

Examples ranged from no communication to an employee about a job change whilst they were on leave, to the introduction of cleaning duties required of paramedics with no communication of the requirement, other than a list of duties being pinned up at the station.

Paramedics reported being sent emails whilst on days off, requiring response by a certain timeframe which did not correlate with their return to shift.

Suggestions were offered on how to improve employee communication and engagement including focusing on sharing positive messages.

A country station manager highlighted the lack of recognition given to employees who actively support organisational goals. They described that they actively practice the St John ethos of supporting healthy, vibrant and self-sustaining communities and making first aid a part of everyone's life, largely by driving several local initiatives and in securing grant monies. Recognition for these efforts is given regularly by the community, but not by St John management. The sense is that in going above and beyond your role description, middle management takes steps to curb enthusiasm rather than recognising the effort. It is claimed this lack of recognition and support has directly contributed to resignations and feelings of isolation.

6.4.3 Independent Oversight Panel's Preliminary Observations

The scenarios described illustrate an organisational culture that is not unique to St John and is reported to exist in many ambulance services.[102] It is possible it may be related to its paramilitary roots and an inability to progressively transition to a professional standards based organisation.

6.5 Operational Management

The issues raised in the vast majority of submissions indicated a number of issues with management capability and application of policy and procedures. The sense is that these issues have arisen largely since the rapid and extensive expansion of middle management drawn from non-ambulance service backgrounds which occurred

[102] ACT Ambulance Service (2015). Enhancing professionalism: a blueprint for change. ACT Government. Available: http://esa.act.gov.au/wp-content/uploads/ACTAS-Enhancing-Professionalism-A-Blueprint-for-Change-Report.pdf

following the increase in Government funding post the 2009 St John Ambulance Inquiry (Joyce Report).[103]

Some submissions claimed that the significant growth of the organisation since 2009 has created an aggressively corporate culture and a layer of new management that has limited experience in understanding and managing emergency services.

Many and varied examples were given of incidents involving management that did not reflect appropriate behaviour for individuals in management positions.

6.5.1 Performance management not used for positive learning

Submissions addressing performance management talk about cases where the performance management process appears not to have been used effectively. Several examples showed an apparently blatant lack of regard for individuals with a punitive approach being taken to performance management; where process was followed seemingly for the sake of it but without regard as to whether it was leading to a constructive outcome.

One submission spoke of an extended performance management plan that involved intense scrutiny with little in the plan that related directly to developing or improving the individual's performance.

Submissions talked of 'hard and fast performance management'; that SJA appears to be ruthless when it comes to disciplinary action, sometimes over minor incidents; and the perception that performance management is used to "*get rid of people*".

6.5.2 Management Practices and Decisions

Discrimination against female officers was cited. A submission detailed the case of a female team leader being treated differently from her male colleagues in shift colour, rostering and leave blocks. She was reportedly denied recognition of qualifications that she had completed alongside her male counterparts, and was excluded from group emails. Management were advised and initially did not act. An investigation was eventually commenced with an external investigator, some six months later.

One paramedic spoke of a manager turning up to a job at midnight at an accident scene requesting a signature on a clinical incident report for a relatively minor injury sustained the week previously. Not only was the timing considered inappropriate, the manager had also reportedly rewritten the formal report, changing substantial material facts. The paramedic was not made aware of any action being taken following a complaint regarding this situation.

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[103] Joyce, G. (2009). St John Ambulance inquiry: report to the Minister for Health October 2009. Department of Health: Perth Western Australia.
Available at: http://www.health.wa.gov.au/ambulance_inquiry/docs/SJA_Inquiry_Report.pdf

One individual indicated their diagnosis of depression with associated anxiety occurred after they had moved into a country role and that it was a direct result of constant managerial bullying, lack of managerial support or consultation and stealthy isolation and victimisation practiced by the upper layers of country management.

6.5.3 Proper procedure not followed

There were a number of reported examples alleging that proper process was not followed and procedural fairness did not appear to be afforded to the individual. Examples provided include: individuals being called to meetings (in some cases immediately, or with a few hours' notice which did not allow for a support person to be present); individuals not being advised of the purpose of the meeting; not being advised of allegations (either in writing or at all) or who the complainant was; no opportunity being given to correct incorrect allegations; nil responses to correspondence relating to complaints; late notice given of mandatory requirements; extended timeframes to resolve issues; witnesses not being interviewed or investigations not taking place at all; breaches of confidentiality; individuals feeling coerced into closing complaints and some officers not being notified by St John that an investigation had finished.

Officers are routinely advised they are not to speak to anyone within the company about investigations and it is unclear whether this applies to seeking support from the Wellbeing and Support team.

Several submissions indicated they did not understand formal processes they were involved in (examples referred to workers compensation, performance management and bullying resolution).

6.5.4 Rostering

Rostering issues were mentioned in multiple submissions with the wide perception that there is a lack of transparency and a disregard for individuals in the rigid rostering practices.

There were reports of individuals being made spare for extended periods of time (multiple years); rostering requests denied without taking into account extenuating circumstances; and inconsistent distribution of day ambulance rosters.

It was stated that unfair rostering is not only inefficient but it causes angst. Officers can be rostered far from their homes and are aware they are have passed other colleagues heading in the opposite direction. Comments were made to the effect that this situation is reported to Rosters with the outcome being they are considered troublemakers.

6.5.5 Management Structure and Resourcing

Several submissions highlighted pressures in station management. It was reported that as depots have grown in size, depot manager roles have grown in duties, leaving little time for depot meetings, effective reporting and timely issue management, and that individuals believed that this contributes to stress and low morale. It was stated that depot managers need additional training and time for management duties and this is increasingly difficult as depot managers are also required to be fully operational on-road paramedics. Workloads also contribute to fatigue.

6.5.6 Independent Oversight Panel's Considered Comments

As with the previous section relating to organisational culture, the issues raised here could also be attributed to the paramilitary history of St John and indeed seem not to be unusual in an ambulance service. Transitioning to professional registration of the paramedic workforce requires a shift in leadership and management frameworks which the Panel feels is at best, a work in progress at St John.

6.6 Policy and Procedures

There were many comments made in submissions and hearings that reflected policy and procedures – both the application of as well as the weaknesses in them, and the impact this has on staff and morale.

6.6.1 Career Transition and Pathways for Paramedics

Career transition and pathways for paramedics was a theme that arose in a number of submissions, indicating it is a broad cause for concern in the paramedic workforce and a source of frustration and stress. When an officer feels their physical or mental fitness is not conducive to continuing in a demanding on-road role, yet they still have much to give to the profession and the organisation, the perception is that there are limited alternative career pathways available to them.

Two submissions reported being told the individuals would need to resign completely, have their leave entitlements paid out and then apply for a patient transport role, with no guarantee of success.

Recommendations made in submissions included: establishing an intermediate level that paramedics have the option to regress to; implementing periodic rotation out of frontline roles; and providing more flexibility in how and when annual leave can be taken.

The establishment of a new type of position was argued as having the potential to bring flexibility to the organisation by establishing crews that still have the ability to work at a higher level than Patient Transport Officers and the creation of specialist

crews for complex transfers that don't necessarily require paramedics but are outside the current scope of a PTO.

6.6.2 Allocated annual leave

Annual leave conditions were reported as being overly restrictive with little to no flexibility in when annual leave can be taken. This means that employees are not able to take a break when they recognise they need to, contributing to their lack of ability to manage stressors, and generally recharge.

6.6.3 Training and development

Training and development related issues were mentioned in multiple submissions. Issues ranged from the lack of orientation into roles (volunteer, administrative country and community paramedic roles) leading to unmet expectations; inconsistency between regions; and a perceived lack of support.

Weaknesses in the mentoring system for new recruits were raised. There is reportedly pressure on trained officers to take up mentoring roles, despite them being unwilling due to fatigue, or not having the appropriate temperament to be a positive mentor.

Several submissions referred to methods and approaches used in training sessions: Trainers using 'we are doing this to toughen you up' approaches; scenario testing occurring in singles when in reality crews work as a team; disrespectful and ignorant approach of trainers to staff under stress; not being allowed to use medication reference resource in scenario training despite using it on the road; clinical placements continuing to be refused after advanced skills training. There is reportedly wide inconsistency between trainers with some students feeling very supported, others felt harassed and inadequate.

Training levels in volunteers were noted, with the argument that as the skill set for paramedics has increased considerably so too should the training for volunteers who work alongside paramedics. The current model is deemed no longer appropriate, causing un-due stress on the sole paramedic in complex call outs such as a child, or adult resuscitation protocols.

Lack of training for management positions was also noted as a concern, particularly the lack of people management training for officers moving from on-road roles.

The issue of interagency training opportunities was raised. Invitations from Department of Fire and Emergency Services (DFES) for paramedics to attend informal training with them involving patient extrication from cars/confined spaces are often not able to be taken up when on shift due to call outs. It was stated that regular training with other agencies would help with stresses of attending motor vehicle accidents. The perception that DFES have much higher training requirements than paramedics was also noted, with the belief this helps with mental stress.

6.6.4 Fatigue Management

The issue of fatigue management featured in many submissions. Apart from volunteers managing on-road duties with their day jobs, the main contributors to fatigue problems reported were patient transport/non-emergency service transfers and long night shifts.

The current fatigue policy makes it a responsibility of employees to recognise and address fatigue by talking to management. It was reported that in reality employees are not in control of workload and cannot therefore manage their fatigue during shifts.

6.6.5 Injury Management and Return to Work

Several submissions raised weaknesses in the injury management framework. The perception appears to be that the default position is that fault lays with the employee until determined otherwise, and that return to work procedures are not supportive.

Situations described in several submissions illustrated insensitivity by management when dealing with employees returning to work after physical or psychological injury. One paramedic was told (politely) they could look for a job somewhere else if they couldn't cope with being reminded of their ambulance partner who had suicided. A subsequent request for consecutive shifts with one single new partner (rather than different shifts with different partners) was referred to Rosters and some months later, a reply had still not been received.

Views are that more personalised support is needed for the injured person throughout the injury management, workers compensation and return to work process, either from the Wellbeing and Support team or an alternative. One submission referred to the 'advocates' model from the Department of Veteran Affairs where an advocate looks after the injured person through workers compensation processes.

Return to work options for psychological injury appear to be limited, unhelpful and create barriers to effective rehabilitation and recovery. It appears the same steps are followed to return employees to work after a psychological injury as a physical injury. For example, there are no reported systems or graded exposure options during a return to work program from PTSD.

One submission described what appear to be unnecessary barriers to returning to work. An officer with PTSD was offered an 18 month secondment in volunteer training as an alternative to being on the road. First, she had to prove she could be operational in an on-road role, which was not achievable due to her psychological injury.

6.6.6 Light Duties

Light duties was spoken of in several submissions, including the rigidity in the process and nature of the light duties work allocated.

All light duties are done in Belmont regardless of the home base of officer, potentially adding greatly to travel time from home. Jobs available are unstimulating and can feel demoralising thereby compounding a paramedic's issues.

The vastly different work roster, model and nature of work can impact mental health and wellbeing which, it is reported, is not taken into account in the rehabilitation process. Whilst on light duties one paramedic was sent to the warehouse to repackage cotton balls into smaller batches, when meanwhile the ambulance training college staff advised they could use additional help assessing student ambulance officers.

6.6.7 Workers Compensation

Workers compensation has been mentioned previously in this summary of themes as it featured throughout several submissions. People spoke of complicated and confusing workers compensation process which people avoid because of the perceived risk of non-reinstatement.

They also spoke of individuals needing more support from the Wellbeing and Support team or independent advocates.

The lack of consideration given to shift workers in the workers compensation framework was also noted.

6.6.8 Independent Oversight Panel's Preliminary Observations

It is clear St John have a comprehensive suite of workplace policies. The issue is not about their existence but about their appropriate and consistent implementation. Awareness raising, training and consequences for non-compliance are all issues that St John must address.

There are several issues here that would be considered as predicted needs of the workforce and therefore St John would reasonably be obliged to provide. Examples include: supported career transition; assistance for the appropriate and timely accessing of compensation and treatment; flexibility with taking annual leave; appropriate non front line roles for officers returning from injury (including consideration for officers used to shift work).

6.7 Issues Specific to Country Ambulance Services

Many issues specific to the country context were reported with many country sites facing challenges that metropolitan sites do not have to contend with. Workload of station management is one example, with country station managers having much broader roles and responsibilities than their metropolitan counterparts.

6.7.1 Unique Context of Country Sites Not Appreciated

A consistent view put forward by respondents from country sites was that head office and the layers of management above regional managers do not accept the unique context and day to day challenges of operating ambulance services in the country. Neither is there an appreciation of how different it is from region to region in terms of distance, remoteness and difficulty resourcing rosters. Country sites reported feeling forgotten and under-valued.

There is a sense of disconnection and lack of understanding from head office, with the view that an over reliance on volunteers is putting the service and the individual volunteers at risk. Despite there being a general lack of resources to cover normal shifts in some regions, efforts to secure additional paid paramedics are not supported. It is argued additional paramedics would provide better roster coverage and fatigue management and would improve clinical safety and quality.

6.7.2 The Volunteer Model

Outside of the metropolitan area there is a heavy reliance on volunteers to provide ambulance, patient transport and event health services to country communities. Many submissions and hearings talked at length about the inherent risks and issues with this model.

Concerns were raised regarding the centralised process for recruitment of volunteers, the limited/non-existent pre-appointment mental health checks and disconnect with local station management.

In volunteer-only sites the expectations on volunteers are extraordinary and range from full depot operation including financial management, maintenance of vehicles, long return trips recruitment and management of volunteers and rosters, and development of funding grant proposals. This is in addition to on-road clinical duties.

The limited rights of volunteers was raised in several submissions. Some submissions raised a concern that as volunteers are not employees it was their belief that they do not have rights under the Fair Work legislation; nor access to unfair dismissal action. When things go wrong there was a sense that as volunteers have only limited rights and in some cases don't know their rights, this is taken advantage of in complaint processes. One submissions raised the concern that volunteers feel they are not treated the same or valued as much as career paramedics.

Volunteer and paramedic respondents alike expressed concern with the disparity between clinical training for volunteers, which could be as little as a first aid certificate, compared to clinical training provided to career paramedics. This contributes to safety and quality concerns and added stressors on career paramedics when partnered with a volunteer. Further, there is no formal orientation or training in the roles and expectations in relation to sub centre business.

6.7.3 Fatigue Management

In all regions represented it was stated there is an expectation a country paramedic will do overtime, come in from days off to cover shifts, or accept immediate call back when additional crews are needed to respond to a high-acuity call out.[104] Several submissions referred to the expectation that individuals will manage their own fatigue when in reality in the country, given service expectations and lack of resourcing this is very difficult.

Additional expectations of a country paramedic include training volunteers, running driver training courses for volunteers, servicing public events, and covering sick leave and other absences. Being required to cover your own shift when attending Continuing Education Program adds pressure when you have to ask a colleague to come in when they are probably already exhausted. This, and extended periods on call, all contribute to high workload and challenges with fatigue management in the country.

6.7.4 Safety and Quality

In all but one depot in WA (Bunbury) career ambulance paramedics work with volunteer ambulance officers. This is in contrast to metropolitan crews which are generally comprised of two career paramedics.

Career paramedics are trained to conduct treatment procedures that require two trained paramedics to administer and yet in country areas may be teamed with a volunteer who does not possess the requisite skill level. In some country depots where volunteers are in short supply the volunteer may only have a first aid certificate and driver's license. In these situations advanced life skills are either not able to be performed or carry added risk.

This creates additional pressure on career paramedics particularly on complex callouts. It was also reported that clinical auditing involving one paramedic and one volunteer follows the same clinical rules as if there were two paramedics, not taking into account the differing skill levels available in the country.

Claims were also made that regional sites do not have the same level of clinical support available as in metropolitan areas.

Standard operating procedures appear to be applied different to the country.

Equipment in country areas is reportedly ageing or not equitable to metropolitan counterparts.

[104] It is acknowledged that officers are remunerated for immediate call back. The main concern raised was difficulty managing fatigue.

6.7.5 Community Paramedics

The role of the Community Paramedics was widely supported with acknowledgement of the challenging role they hold. Community paramedics have broad responsibility for multiple sites, including support and training of volunteers. In addition, they hold advanced clinical skills. There was report of community paramedics being on call 24/7 for several weeks, which may be due to insufficient volunteer numbers in certain locations.

Several submissions raised the risk of skill loss in Community Paramedics in small communities with low activity, and no real organisational action plan or policy to address this. The concern is that when there is, for example, a motor vehicle accident there are usually several occupants of the vehicle who may require advanced to basic lifesaving skills.

The Community Paramedic role is perceived as being mainly to recruit, train and retain volunteers with this duty increasing in recent years.

6.7.6 Country Procedures within the State Operations Centre

A number of issues were raised relating to procedures for country calls within the State Operations Centre (SOC). It is claimed that any callouts in the country are drawn out and dangerous due to distances between towns and hospitals and broadly, issues associated with the volunteer model. Further, the systems and procedures put in place to manage country calls and dispatches are not able to work effectively due to staff shortages in the SOC meaning support staff are diverted to taking overflow emergency calls.

Several procedural improvements were raised which it is claimed would improve efficiency in country calls. These included: ensuring the country support officer is available to support the country dispatcher rather than allocated to emergency call overflow; transferring responsibility and process for identifying second crews in paid country depots to the local paid crew rather than the country dispatcher; and removing auto-booking of volunteer centres when there is in fact no crew available.

6.7.7 Certain policies don't apply in the Country and some practices discriminate against Country officers

It was reported that there are policies and procedures in place which either do not apply in the country or directly discriminate against country-based staff.

Job share arrangements are reportedly not available in the country and the view is this could provide additional paramedic resources to depots where paramedics are struggling with workload.

Practices apparently preclude country officers from selection for country relief positions due to increased costs and administrative efforts involved compared to

selection of metropolitan-based paramedics. A paramedic apparently must take annual leave to undertake relief positions due to the impact on country rosters of staff movements.

Attendance at Continuing Education Programs requires country staff to fund their own travel and organise their own shift coverage. Given the issues with shortage of staff in country regions this can be challenging.

6.7.8 Independent Oversight Panel's Preliminary Observations

The Panel has significant concern with the model of country ambulance services, particularly those largely volunteer-based, in terms of risk to individual volunteers and safety and quality risk to the community. Fatigue, treatment of victims with whom you have a personal relationship and depot management responsibilities including fundraising for core equipment, place significant strain on volunteers and the paramedics they may work with. Extended periods on call is high-risk and does not provide adequate opportunity for rest, recuperation and settling of stress.

Screening and ongoing support for volunteers is critical and adequate resourcing and support for country-based paramedics is also critical.

Safety and quality risks arise through limited training of volunteers compared to degree qualified paramedics, second-hand equipment and unsafe practices dictated by remoteness and lack of available volunteers to fill rosters or provide back up at complex cases.

This is not St John's issue to solve alone and requires the cooperation of the State Government, predominantly via the WA Country Health Service.

6.8 Issues Specific to the State Operations Centre

Several submissions directly addressed issues within or relating to the State Operations Centre (SOC). These submissions clearly articulated specific issues which is claimed directly affect the effective and efficient operations of the SOC and morale of the staff. Staff are reportedly frustrated by the perception of limited interest in the SOC by St John management.

6.8.1 State Operations Centre procedures

There were very specific comments made on operational procedures involving calls via Police, or communication with Police on attendance at scenes. It was reported in several submissions that a breakdown in procedures has contributed to paramedics fearing for their safety or being assaulted by a patient.

It was also reported that ambulance crews can be sent to an address or patient where it is known by the SOC to be dangerous without the crew being notified.

Communications Officers appear not to pass on pertinent information apparently repeatedly.

A further example was given relating to code black safety procedures. Following being assaulted and the paramedic informing the SOC over the radio, the correct procedures of dispatching a backup ambulance were not instigated. An incident report was submitted regarding the incident but at the time of the submission, no response had been received.

6.8.2 Resourcing and Systems Issues

A lack of staff was raised as contributing to the use of key support roles in taking overflow emergency calls and minimal downtime if any (working up to 6 hours straight), after taking a traumatic call. The automatic connection of emergency calls will often result in no time between calls. Significant weaknesses were also reported with the IT systems.

6.8.3 Organisational Culture in the State Operations Centre

There were examples provided of bullying being experienced or witnessed, as well as discrimination in promotional opportunities.

A myriad issues were identified in relation to the facilities and work environment of the SOC. It reportedly has limited staff facilities and suggestions made by staff to improve the workplace are generally denied. Alternatively, initiatives are implemented without all staff being consulted.

Dangling cords, broken foot stools, locked unusable drawers, ineffective air conditioning and a generally messy environment were all mentioned.

Procedural changes are made without all staff being informed and appropriately trained first. There is reportedly only limited time dedicated at Continuing Education Programs for training with 'non-live' systems. Expressions of Interest are not sought for promotional opportunities.

6.8.4 Independent Oversight Panel's Preliminary Observations

The Panel was left with an impression that Communications Officers are not necessarily recognised as first responders, despite being on the front of the frontline. They experience trauma and fatigue similar to paramedics.

From the information provided it is difficult for the Panel to determine whether the issues described above are due to human error or a failure in the system. The Panel is aware that Communications Officers are distressed about failures in systems, procedures and protocols, and the impacts these failures have on themselves and their colleagues in ambulances.

For all concerned, it is important faith is restored in protocols and procedures for the health and safety of all.

6.9 The Wellbeing and Support Model

The focus of the majority of submissions was the wellbeing and support model in place. Issues raised varied greatly and whilst the vast majority expressed negative views, there was positive reflection in a small number of the submissions.

There is a wide belief that the new model was developed and implemented with limited consultation with staff; it is not evidence-based and the staff are inexperienced in provision of mental health services but it was felt, more importantly, inexperienced in emergency services work.

It is acknowledged that the wellbeing and support resources have been increased. However, this does not appear to have addressed the root cause.

The appropriateness of advice provided by the Wellbeing and Support team as well as the services offered were raised. One submission recalled being called by the Wellbeing and Support team the day after a suicide case and the support officer 'umm'ed and err'ed' their way through the conversation. This did not foster confidence or trust. Another recalled being contacted after a high profile call-out and the wellbeing team asked inappropriate questions likening it to a journalist trying to obtain the latest scoop.

The view that the Wellbeing and Support team is not visible on the road and has not created personal connections with operational staff was expressed in many submissions. The wellness staff are not known to people on the ground. The importance of face to face support is felt to have been lost.

The self-help model was the focus of many comments - requiring staff to make decisions for themselves when not equipped to in their current mental state.

The fact there is no formal engagement of specialised PTSD clinics was noted, with St John opting to use non-specialised services instead.[105]

Submissions referred to the presence of WAPOL and DFES Chaplains at callouts, the perception being these organisations have a better, more organised support service. Paramedics stated they saw the WAPOL Chaplain more often than their own, and received more support from them. It was noted that a DFES or WAPOL Chaplain or support person can be at the scene of a fatality in metropolitan Perth before the ambulance crew leaves and yet the ambulance crew often don't receive a phone call from their own Wellbeing and Support team. It was also reported that local hospitals

[105] St John has subsequently indicated it has formed a relationship with The Marian Centre, a private psychiatric hospital. The Panel is not aware of any specialisation in the treatment of emergency service personnel

can organise debrief and counselling sessions including paramedics within hours of an event yet it takes days to get a phone call from St John Wellbeing and Support services, if at all.

6.9.1 Support from Management, Lack of Debriefs and Down Time

The lack of downtime between call outs was raised in several submissions.

There is reportedly an expectation of St John that paramedics will be back on the road and operational within 20 minutes of handover in order to meet KPIs. Following a complex call out involving multiple crews it was reported that all crews were made operational straight after debrief and two were given priority ones. It was felt that as a duty of care to both crew and public, crews should not be despatched on priority one within minutes of clearing from debrief.

Submissions spoke of the inconsistent approach to wellbeing and support taken by area managers. Some are sympathetic, will contact the Wellbeing and Support service for follow up and may send the crew home after a particularly traumatic job. Others advise to '*suck it up'* or '*you'll be ok'*.

The dual role of 'performance manager' and 'peer supporter' leads to paramedics feeling uncomfortable to raise their own wellbeing issues with their line manager for fear it influences the perception of their ability to perform. The fear that seeking support could lead to an individual being deemed unfit for work was mentioned in several submissions.

The absence of debriefs was a commonly raised issue.. One paramedic reported attending one in ten years, another has not been able to attend any in eleven years.

One submission questioned why the Wellbeing and Support team apparently had mandatory monthly debriefs with an outside agency when this is not deemed necessary for on-road staff.

6.9.2 Self-referral model

The move to a self-referral model was not viewed positively in submissions and hearings. Its evidence base and perceived 'one size fits all' approach was questioned in both submissions and hearings.

Submissions talked of the self-help approach being more appropriate for the younger generation than it is in older generations where it does not happen so naturally.

6.9.3 Resourcing and experience of the team

The lack of clinical qualifications in the Wellbeing and Support team was raised, but more so, their lack of experience in emergency services roles. People reportedly feel

reluctant to approach the team due to its limited experience with the realities of a frontline role.

The lack of use of current or retired officers in the support team was raised as a weakness, noting that WAPOL and DFES have uniformed Chaplains. Retired officers in peer support roles and/or playing an advocacy role for injured paramedics through the workers compensation process were suggested as a strategy to connect operational staff with the support team at the same time as providing a valuable role for ex-employees.

It was suggested that there should be a chaplain on each shift, plus one in the country as this would provide more opportunity for successful contact by employees.

6.9.4 System weaknesses and Lack of Consistency in Follow up Post Traumatic Events

The majority of submissions spoke of the seemingly random nature of follow ups from the Wellbeing and Support team after particularly complex or traumatic jobs. Some indicate the support team did initiate contact after a critical incident, within a varying number of days, weeks or months, whilst the majority of others reported they have never been contacted in such circumstances.

Several comments were made about the 24 hour phone line and calls not being returned.

One submission did speak positively about the support received three years ago whilst in a country volunteer role. The support received afterwards was "*tremendous" and included multiple phone calls from staff to check on my wellbeing and invited me for coffee and a chat*."

Another spoke of being booked off for four days after a major incident but nothing else was done by St John. There was apparently no other contact.

6.9.5 Equal Access to Wellbeing and Support for Country and Metropolitan Staff

Several respondents talked of the lack of formal wellbeing contact and support for country-based paramedics and volunteers, and the need for an approach which ensures country staff are provided the same level of support as the metropolitan service.

Fly in fly out clinical psychologists have been organised but continuity of sessions was reportedly not guaranteed.

6.9.6 Training / Suicide Prevention Awareness

Submissions talked about the importance of education and training in suicide prevention but that it is adhoc with some individuals noting they had never received any training while others had, albeit a very limited amount.

Information provided in the submissions indicates management may not be identifying signs of mental illness in their staff due to having inadequate training and support. A further issue was raised in the conflict of the management role – one of support versus one of discipline.

6.9.7 Support for State Operations Centre

Specific comments were made about the approach to supporting officers in the State Operations Centre. Communications officers raised concerns that they feel they are not considered to be impacted the same way as paramedics, despite dealing with traumatic calls. There is no monitoring of calls or tracking of impact on the call takers.

It was also raised that there is no training for emergency call takes in how to talk to patients with mental health problems when keeping them on the phone.

Reportedly, the Wellbeing and Support Team has visited briefly perhaps twice in the previous year (2014/15) and when asked why they do not stay for an extended period to learn how the room works the reply was that whilst it could be useful it wasn't necessary in order for them to offer support.

6.9.8 Support Needed For Ex-Employees

The issue of supporting ex-employees after their employment with St John ceases was raised in several submissions with paramedics feeling this was an important factor in acknowledging the risk factors associated with the work of a paramedic and supporting the workforce generally.

6.9.9 Independent Oversight Panel's Preliminary Observations

Qualifications of the Wellbeing and Support team both in provision of psychological care and in emergency services is a critical issue which needs addressing. Increases in resources in the Wellbeing and Support team are acknowledged, however, the Panel is of the view this expansion has been misguided because of a fundamental ignorance of the psychological risks in the emergency service workforces. Claims of being an evidence based service cannot be supported by the Panel.

Continued over-reliance on a self-referral model cannot be supported by the Panel. The issue of responsibility for the worsening of severity and prognosis for those who remain in the workplace needs to be considered.

Communication to staff that further promotes the evidence base underpinning the Wellbeing and Support model, and that addresses the unique needs of an ambulance service workforce will go a long way to allaying staff concerns of the adequacy of the model.

6.10 Employment Conditions

There were very few comments relating to the employment conditions of a paramedic being a contributing factor in stress and mental health issues.

There was some comment on the different employment conditions between administrative staff and paramedics – with paramedics not having access to the two stress days available to administrative staff, and having to wait 10 years rather than seven to access long service leave.

The use of sick leave when booking off for fatigue management was a point raised in several submissions.

Several submissions spoke about the excellent conditions in terms of wages, holidays, shift options and special leave.

7 Independent Oversight Panel's Findings

7.1 Introduction

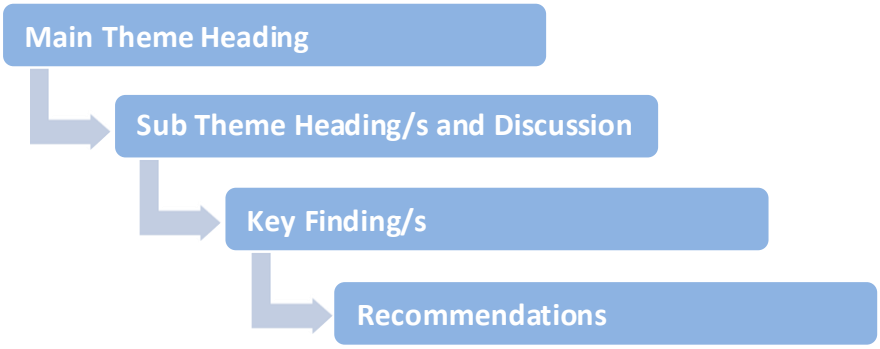
This Chapter discussed the considered view and findings of the Panel. The discussion incorporates the substantial information received throughout the review process through hearings and written submissions, presentations from and discussions with management of St John, the United Voice WA committee of union representatives, other emergency services agencies and the Chief Psychiatrist, as well as the written Reports of both the Chief Psychiatrist and Phoenix Australia. In addition a range of other reports and literature has been considered.

7.1.1 Format of this Chapter

The Panel has summarised its findings into the eight main themes of:

- Nature of Ambulance Service Work
- Wellbeing and Support Model
- Operational Management, Policies and Procedures
- Issues Specific to the Country Ambulance Service
- Organisational Culture
- Appreciation of the Legal Context
- Governance, Accountability and Risk
- Relationship with United Voice WA

The discussion on each theme is structured as follows:



At the conclusion of the Chapter the Panel provides some comment on the implementation of its recommendations with a view to ongoing oversight and reporting.

7.2 Nature of the Ambulance Service Work

Employees in emergency service settings operate in unique contexts facing challenges not experienced by other workers. The *Phoenix Australia Report* articulated this well, stating that St John employees are exposed to a range of psychological risks during the normal course of their work including shift work, potentially traumatic events, working in a high demand, low control environment, and for some, working in a geographically isolated area.

There can be no doubt that the work of those in frontline ambulance service roles, including paramedics, communications officers and volunteers is unpredictable, stressful and challenging and that there are many complex factors contributing to this. There is, in the Panel's view, an ample body of national and international literature to characterise these risks and the available evidence about strategies for intervention.

Submission and hearings undertaken by the Panel were generally silent on the connection between the nature of the role as a first-responder and mental health problems. However, this was not surprising, as previous studies have shown that frontline workers generally accept these exposures as part of their work, but generally underestimate the associated risk. What the workforce does not anticipate is the organisation stresses which they argue exacerbate unnecessarily, the consequences of the traumatic stresses in the workplace. They did however, raise the need for downtime between jobs as a crucial self-management strategy, noting that this can often be challenging to access.

Participants consulted were generally positive about their employment conditions in terms of pay, roster structure and leave allocations. Some staff noted long shift lengths directly contributed to fatigue, and the lack of flexibility in rostering and the taking of leave are not conducive to effective self-management of fatigue. Consultations also revealed that organisational and workplace factors relating to management style and decision-making processes, lack of communication and the existence of bullying as being the major contributors to feelings of stress at work.

It was apparent that individuals who choose to work in frontline emergency service roles (paramedics, volunteers and communications officers) tend to have high levels of commitment to their first-responder roles and for serving the community. This was an overwhelming sense the Panel gained through its consultations. It seems appropriate then, that the community and the employer owes these first-responders a particular duty of care if they are injured or become unwell, whether physically or psychologically.

Individuals expressed sincere loyalty to 'the Saint' and to each other and were highly committed and vested in the success of the organisation and its continued service to the community. The Panel did not at any time get a sense those at risk of psychological injury were a small group of staff who need special consideration and posed a particular challenge to management. Individuals were honest and balanced in their accounts of their treatment and of their own personal actions or reactions. Some

showed emotional scarring being deeply affected by the deaths of their colleagues, the mental health struggles of other colleagues and the trauma of their role as first responders.

7.2.1 Wellness of the Ambulance Service Workforce – Evidence from the Literature

As detailed in Chapter 2, there is a significant body of literature which describes the higher risks and disorders associated with emergency service personnel. To recap:

- Evidence from a variety of research indicates that the cumulative impact of trauma exposure increases the risk of PTSD and other adverse health outcomes. Thus, it is important to consider lifetime trauma history, accumulated in the course of an emergency service career and the risk of suicide.
- Evidence indicates that emergency service personnel have a significant risk of developing posttraumatic stress disorder in the course of their working career. The risk is more than double the general population and is higher than for police officers or firefighters.
- Exposure to traumatic events is a specific risk factor for suicidal ideation and suicide attempt.
- There is a relationship between physical and psychological morbidity.
- The adverse health outcomes of an ambulance officer are related to a matrix of factors, including the cumulative traumatic stress involved in the role, organisational factors and individual risk factors.
- A percentage of individuals exposed to traumatic events have a progressive development of symptoms with the passage of time which supports the early identification of symptoms in emergency service workers because it highlights significant levels of current morbidity and the future risk to the workforce.
- Organisational and workplace factors including social aspects of the work environment are predictors of PTSD, burnout and fatigue. These include lack of social support from colleagues, lack of social support from supervisors and poor communication.
- There appears to be a link between length of service and less recovery time between incidents and higher levels of burnout and posttraumatic stress symptoms. Moreover, experienced staff are expected to cope better and as a consequence were more reluctant to express their distress. It highlighted that managerial staff had tended to be less alert to the needs of these experienced staff and the early warning signs of difficulties in this group.
- The mental health consequences of bullying and harassment have been well documented in a variety of occupations.
- People with PTSD, mood disorders and substance abuse disorders have been shown to have an increased rate of suicide, with approximately 90% of people who attempt suicide having a psychiatric disorder, such as depression, and posttraumatic stress disorder.

- Completed suicide is generally preceded by some form of suicidal expression such as ideation, plans or attempts, thus identifying and focusing on suicidal thoughts and behaviours provides effective opportunities to prevent suicide deaths.
- There is a positive relationship between cumulative trauma exposure and likelihood of suicidality.

It is also important to acknowledge and offer support for the impact of exposure to trauma and stress, and mental illness on families of emergency service workers. The Panel heard from several people who indicated their challenges in the workplace were impacting their relationships and family life.

7.2.2 Career Transition and Pathways for Paramedics

A significant issue that arose through consultations was the lack of career pathways or alternative roles for paramedics who cannot continue to work in on-road roles, due either to psychological injury or physical injury or capacity. The question of transitioning these individuals into different roles and career paths in order to retain their expertise in the organisation is critical and currently appears not to be a strong focus within St John. This raises the question of the responsibility of St John to retrain staff and/or provide alternative duties if ongoing exposure to the traumatic stresses of the workplace represents an unacceptable risk to the individual's further health and welfare.

Neither is there a strategic workforce plan in place which maps expected longevity in frontline paramedic roles or injury management strategy. This would help inform the proactive identification of employees whose capacity to work in frontline roles is diminished and is posing a risk to themselves or the community.

There was a view expressed by St John that there is a small number of paramedics who were trained in the old model who either do not want to, or find they cannot work with the contemporary paramedic scope of practice, but for whom the pay and conditions are too good for them to leave voluntarily. The Panel acknowledges that this may be a very valid issue however is also of the view that creative thinking (in conjunction with the workforce and workforce representatives) around workforce roles may provide valuable alternative employment, and the ability to retain knowledge and expertise within the organisation. It is important that St John consider the risk and liability of retaining individuals who have significant untreated psychiatric disorders in frontline roles that may impact on their clinical performance. Active support through the compensation system with appropriate treatment and rehabilitation for individuals with legitimate psychological injuries needs to be part of a workplace strategy of risk management.

The most obvious pathway is movement into a Patient Transport Officer (PTO) role and the Panel is aware this does occur from time to time. The stated limitation is the low number of PTO roles available. More long term alternatives such as introducing new workforce models will require collaboration with the workforce and workforce

representatives, and United Voice WA management has indicated a willingness to work with St John on this.

There should also be a serious option for suitable officers to move into wellbeing and support roles.

A particularly innovative proposal raised with the Panel was the notion of dual parallel qualifications. In this scenario a student would complete additional units at the same time as their Paramedicine undergraduate degree and be awarded a second degree or certificate on graduation which would allow them to more easily transition into an alternative career path such as nursing. This would require significant work with Curtin University, the current partner with St John for education of student ambulance officers, but is considered by the Panel to be a worthwhile concept.

7.2.3 Organisational awareness of the issues

There is no avoiding the nature of the job in frontline emergency services work. Due to this, St John is required to anticipate the possible traumatic exposures that may affect its workforce and have strategies to deal with the effects in the workplace, particularly the negative mental health outcomes in some personnel.

From the evidence provided through the Panel's consultations with participants the Panel is of the view that management (individuals and systems) at all levels within St John do not have an adequate appreciation of the prevalence of mental illness in the workforce. Further consideration needs to be given to systems to better recognise symptoms of mental illness and development of strategies to better manage them. The link between physical illness and injuries, and mental health also appears to be under-appreciated. The reasons for this could be attributed to a lack of consultation of contemporary evidence, and lack of suitably qualified mental health professionals within the Wellbeing and Support team.

The lack of awareness of the evidence by St John was perplexing for the Panel. St John is a front line service delivering high quality pre hospital care according to evidence based clinical protocols. That the same organisation does not appear to be using contemporary evidence bases to develop protocols for the identification and treatment of psychological illness in its own workforce, concerned the Panel.

There was a view expressed by St John that the levels of physical injury reported far outweighs the levels of psychological injury reported and that mitigation strategies need to take this weighting into account. The Panel acknowledges that whilst this may be the case, the consequences of poorly managed psychological injury can be catastrophic for individuals, families and communities and hence requires serious consideration. Equally, the outcome of physical injuries is substantially impacted by whether the injured worker has a co morbid psychological disorder.

7.2.4 Organisational response to the issues

The Panel is of the view there is openness amongst St John's executive to do the best it can for the community. In this context it is worth spending some time commenting on St John's response to the issues surrounding the various reviews undertaken in this area and the actions it has taken to address the resulting recommendations.

The 2012 report of the Community Development and Justice Standing Committee into the Toll of Trauma on Western Australian Emergency Staff and Volunteers[101] provided clear direction to all emergency service organisations in Western Australia on improvements needed to strengthen psychological support for their workforces.

The *Toll of Trauma Report* failed to explicitly mention St John in many recommendations relevant to it and it is assumed this is because St John is not a State Government agency. Whilst apparently not obliged to take action, the *Toll of Trauma Report* did present St John with an opportunity to take a proactive approach to addressing shortcomings in its model.

For example, there were recommendations relating to implementation of trauma tracking systems, managing trauma exposure in volunteers in country areas, provision of funding for implementation of Psychological First Aid, additional resources for peer support programs; consideration of a role for retired staff as mentors or peer supporters; and implementation of exit interviews for all staff and volunteers.

Subsequently, the crisis in the organisation over the issue of suicides in its workforce appears to have been dealt with in a seemingly uncoordinated way with a tendency for defensiveness rather than proactivity.

It is the view of the Panel that the lack of reflective self-criticism and learning is a concern in a health service organisation which must be adept at managing challenges and crises.

An ambulance service is an organisation focused on health outcomes. As a consequence, its methodology is about ensuring optimal protocols and interventions based on the available scientific literature. Hence, this sector of the emergency services has the facility to be a leader for the emergency services generally, about the area of occupational health and the impact of the specific hazards to employees.

It is the view of the Panel that the Board of Management of St John plays a critical role in this. St John must take action now in order to avoid the situations that have been played out in other industry sectors.

Finding 1
It is the view of the Panel that there appears to be a degree of reluctance by St John to accept the magnitude of the risk presented by the day to day work of paramedics, communications and transport officers. The Panel's view is that this is due to a failure to thoroughly consult contemporary evidence. Consequently, there appears to be a lack of appreciation for the extra care needed to ensure this psychological risk is managed adequately.

Finding 2
It is the view of the Panel that because of the increased psychological risk to ambulance service workers, St John has a duty of care to provide a comprehensive and integrated model of wellbeing support ranging from identification/screening, early intervention, effective triage and management of care, and adequate access to immediate and ongoing specialist care.

Finding 3
It is the view of the Panel that improved workforce planning and support for career transition pathways will improve options for staff who can no longer work in frontline roles but who still have value to add to the organisation.

Finding 4
It is the view of the Panel that in the interest of moving quickly to allay concerns and minimise damage, St John's response to the issues to date surrounding the alleged suicides in the workforce have been overly and unnecessarily defensive and reactive. St John now has an opportunity to develop a long term strategic response.

Recommendation 1: Formalise understanding of the unique psychological needs of the ambulance workforce

It is recommended that St John engage a qualified mental health professional with expertise in emergency service workforces to assist the organisation to develop a formal position on the unique needs of the ambulance workforce and ongoing needs for mental health care.

Integral to this is an up to date expert and comprehensive knowledge of the relevant literature.

Recommendation 2: St John Workforce Mental Health Study

It is recommended that St John consider conducting a study into the mental health of its workforce and the risk factors for disorder, including suicidality. There would be merit in establishing this as a longitudinal study which would feed into continuous improvement of the wellbeing and support model and would allow St John to regularly measure the effectiveness of its model.

Consideration could be given to expanding this to include all emergency service agencies in Western Australia which would give this State a leadership position in the country.

Recommendation 3: Career Planning and Transition

It is recommended St John work collaboratively with the workforce and workforce representatives to develop more effective career transition pathways underpinned by a strategic workforce plan and actuarial model of the workforce. Consideration should be given to options such as dual qualifications, and creation of new workforce roles including roles in Wellbeing and Support.

7.3 Wellbeing and Support Model

The Panel was informed of the history of the current model of wellbeing and support in St John.[106] The model has grown from a single Chaplain covering the entire state and workforce, with dedicated trained peer supporters, to a dedicated team of ten full time equivalent positions with the whole workforce acting as peer supporters. It is acknowledged that significant investment has been made into this critical service reflected by an expansion of services provided and personnel employed.

For the most part, the stated goals of the new model[107] are appropriate, if appropriately implemented:

- A dedicated wellbeing and support team
- A plan to cultivate a culture of shared responsibility for wellbeing
- Plan to try to remove/reduce the stigma of mental health
- Implementation of a comprehensive suite of professional referral options
- Embrace organisation's clinical approach, ie be strong evidence based
- Approach education based: ongoing, annual, organisation-wide education

Given the nature of ambulance work and the literature available describing the psychological risks associated with ambulance work, there can be no denial of the importance of a multi-faceted, integrated health and wellbeing model. The Panel acknowledges that St John has made significant progress in this.

The conclusion the Panel has reached however, informed by its own consultations and examination of relevant reports and documentation, is the St John Wellbeing and Support Model is not adequate for a workforce with known psychological risks. Despite the views of St John management, the model is not sufficiently evidence-based or reflective of the relevant published scientific literature.

[106] St John Ambulance Well Being and Support Services: The Journey 2001 - Current
[107] CEO presentation to the Independent Oversight Panel – 10 August 2015.

This section will highlight some of the strengths and weaknesses of the model as perceived by the Panel.

The growth in referrals to the Wellbeing and Support team in recent months is being seen by St John as an indication of the model's effectiveness. From the data provided to the Panel it is not possible to comment on the drivers for the increased activity. It may be an increase in unique presentations or a smaller group of repeat users. It may be indication of growing satisfaction in the service but it may also be an indication of increased problems in the workforce for which employees are seeking support.

As referenced in the *Toll of Trauma Report*, the Queensland Ambulance Service attributed an increase in the utilisation of its wellbeing service to a significant increase in younger recruits joining the service through the university degree program.

In summary, an increase in activity alone should not be relied upon as the key indicator of success of the wellbeing and support model as it does not reflect the clinical effectiveness of any interventions. This would be the basis of reporting the true success of the model.

7.3.1 Implementation of the new model

St John's current model for wellbeing and support was introduced in 2012. It came at a time following the significant growth in activity and size of the workforce, and following the retirement of the previous Chaplain. Upon commencement in 2012 the new Chaplain spent time immersed in the organisation in an attempt to gain an understanding of the needs of the workforce in terms of mental health and wellbeing and how best they may be met. This was commendable.

The Panel was advised this included a lengthy period of consultation where the Chaplain travelled across the state meeting and talking with many staff in order to inform the new model. Despite this, during the consultation period the Panel gained a sense from participants that they were not consulted or that they felt unheard in this process as their needs have not been addressed. This would corroborate the findings of the Chief Psychiatrist.

7.3.2 Use of the Evidence Base

It is the view of the Panel that St John's Wellbeing and Support Model does not adequately address or provide an integrated service that factors the unique nature of its workforce in relation to its increased risk of psychological injury. As illustrated in Chapter 2, there is ample literature and published guidelines available which indicates the increased risk of psychological injury in the emergency services workforce and the need to have preventative strategies in place.

The emergency services are an example of high-risk workforces that demand clear policies and procedures within an organisation. The challenge being to minimize

potential for injury to individuals and lessen the cost to organisations through the optimal application of preventative strategies.[97]

Early intervention is fundamental to successful outcomes for individuals suffering PTSD or other psychiatric disorder. Continued exposure to traumatic stress by an individual with depression or PTSD poses a significant risk of increasing the severity of the disorder and decreasing the probability of a good treatment outcome. Systems that ensure early identification include screening, removing stigma and trauma tracking. This is in addition to appropriate reactive or treatment strategies and regular ongoing education programs.

Strategies and specific guidelines have been set out for the diagnosis and treatment of trauma-related disorders in *The Australian Guidelines for the Treatment of Adults with Acute Stress Disorder and Posttraumatic Stress Disorder*.[98] The Guidelines include a specific section focusing on the predictable risk of mental disorder in emergency service and military personnel.

More recently, world-first Expert Guidelines for the Diagnosis and Treatment of Post-Traumatic Stress Disorder in Emergency Service Workers have been released.[34]

A further valuable resource which has very recently been released is the Report of The Senate Foreign Affairs, Defence and Trade References Committee - *Mental health of Australian Defence Form members and veterans.*[108] Amidst a range of issues relating to prevalence, identification and disclosure, barriers to accessing support, and diagnosis and treatment, the *Senate Committee Report* discusses at length, the issue of screening.

Clinical guidelines show that twelve cognitive therapy sessions are generally required for the effective treatment of PTSD following careful clinical assessment. It is St John's policy that employees are provided with six free sessions under the Employee Assistance Program and that this was increased from three in recent years (*St John has advised that the policy and practice allows for individuals to access more than six sessions depending on assessed need*). The policy must be flexible enough to address cases where an individual requires more than six sessions for a successful outcome, or indeed requires specialised treatment which may be unable to be provided through the standard EAP provider. Cases were shared with the Panel during consultations that indicate the policy has been applied rigidly in the past.

The Panel urges St John to avail itself of expert material available.

Further, the Panel would urge St John to consider commissioning an independent assessment of the value of what has been provided in its new Wellbeing and Support Model as it stands up against the evidence.

[108] Foreign Affairs, Defence and Trade Committee, (2016). Mental health of Australian Defence Force members and veterans. Commonwealth of Australia.

Further, engagement of appropriate qualified mental health professionals in the development, implementation and ongoing evaluation of the Wellbeing and Support Model will be critical to its effectiveness, and in its credibility amongst a highly trained clinical workforce.

Ongoing monitoring and evaluation of the model will be critical to ensure it remains based on evidence.

7.3.3 Self-referral model

It is the Panel's view St John's reliance on a model of self-referral for psychological support is not supported by the available evidence. Issues of stigma and an inability to self-identify being in need of assistance, contribute to its lack of effectiveness. That said, it is still an important underlying strategy and removing the stigma associated with mental health should continue to be a focus. In addition to education programs there may be something to be learned from efforts in the medical profession which have seen the separation of self-disclosing of mental health conditions in doctors from the Medical Board to a third party.

7.3.4 Workforce Screening

Screening should be considered for high-risk individuals such as in those working in emergency services and many such organisations have implemented an annual screening regime. This approach is supported by aforementioned Australian Guidelines for the Treatment of Adults with Acute Stress Disorder and Posttraumatic Stress Disorder. As mentioned above it is also discussed at length in the recent *Senate Committee Report* into Australian Defence Force mental health issues.[108]

Screening should occur prior to appointment into a role, periodically throughout employment and ideally upon exit from the organisation.

Annual testing would be critical in the proactive identification of individuals who are experiencing distress, and follow up intervention would allow the assessment, diagnosis and treatment for these people.

Implementing a screening system in conjunction with a tracking system will enable St John to more effectively understand and monitor the overall health of its workforce and will help devise, implement and improve services. It is acknowledged that there will be sensitivity around implementation of such a strategy, particularly into an organisational culture where a degree of cynicism and lack of trust persists. Hence, clear communication about the evidence base and the protocols will be essential.

7.3.5 Tracking Exposure to Trauma

Currently, St John does not have in place a mechanism or system for recording and flagging which of its staff had attended a certain number, or type of traumatic events. Implementation of such a system was a recommendation of the WA Parliament's 2012

Toll of Trauma Report. The Panel heard that the WAPOL and DFES have systems in place, albeit with recognised weaknesses.

Implementation of a tracking system allows the recording of exposure of individuals to traumatic calls or callouts, and follow-up either periodically after a set number of callouts, or immediately after a particularly traumatic incident.

That there is no system to flag call-outs of a particularly severe or sensitive nature for immediate follow up from the wellbeing and support team was not anticipated by the Panel due to the strong face validity of this approach. There were many stories shared by employees throughout the Panel's consultation of individuals not receiving any contact by the Wellbeing and Support Team to proactively enquire as to their wellbeing, and numerous examples where a partner (or volunteer) was contacted but the paramedic involved wasn't.

Likewise, the fact no system exists to track an individual's exposure to trauma over a period of time disturbed the Panel somewhat, and is an example of St John's reluctance to recognise the effect of cumulative exposure to trauma.

It is the Panel's view that both systems are foundational to a proactive and effective Wellbeing and Support Model for an emergency service workforce. It was made known to the Panel that no other ambulance service in Australia has a longitudinal tracking system in place. Whilst there may be legitimate reasons for this, the Panel could not identify any. That St John may become a leader in emergency service employers to implement a comprehensive system in the Panel's view, would be a notable achievement for the organisation and the State.

7.3.6 Debriefs and Downtime

While evidence suggests that psychological debriefing has no demonstrated benefit, the value of early intervention and self-management techniques are more generally supported.

An important strategy which staff involved in Panel consultations spoke of more strongly than debriefs, was being able to access downtime between traumatic jobs so that they can more effectively peer and self-manage. It was reported that this can be challenging to access and often, there is no opportunity at all.

7.3.7 Peer Support

There is less formal evidence of the success of peer support programs, however they are relatively common in emergency service organisations. St John's approach is that its 6,000 plus workforce is trained and mobilised to support each other. This may be an obvious strategy given a proportion of the workforce would be expected to possess a level of psychological first aid competency as part of their clinical service role. The Panel's view is that clinically and occupational health and safety-wise, this approach is valuable but insufficient.

The Panel is of the opinion that a more formal peer support program needs to be implemented as a strategy in addition to the whole of workforce approach. This small group which would include uniformed officers would receive more dedicated training and would play formal roles linked to the wellbeing and support team. This requires a well-developed training program and ongoing supervision of the peer support officers by trained mental health professionals.

7.3.8 Education and Training

St John is to be commended for its approach to providing awareness-raising through psycho-education and training to its entire workforce. It is important these efforts continue so that stigmatisation of mental health in the workforce is progressively removed. This training should also incorporate training in strategies for officers to deal with highly distressed victims and relatives at accident scenes or other medical emergencies.

More specialised training is also required of any person in a managerial role so that the signs of psychological injury are more readily recognised and appropriate management strategies can be instigated.

Awareness-raising education for partners and family members is also worth considering.

7.3.9 Injury Management and Return to Work

Processes and systems around injury management and workers compensation were a focus for a number of employees involved in Panel consultations. Experiences relayed to the Panel painted a picture of a punitive system of injury management which lacks appropriate instigation of workers compensation for psychological injury, and ensuring appropriate treatment of and support for individuals throughout the process. As already stated, the Panel cannot comment fairly on the claims of individuals in cases such as this.

However, it is the Panel's view the surprisingly low number of workers compensation claims for psychological injury in the St John workforce is likely to be indicative of stigmatisation associated with seeking formal injury management support, rather than an indication that psychological injury does not exist.

Some staff described insensitivity by management when dealing with employees returning to work after physical or psychological injury. Whilst unable to comment on whether this is a widespread attitude it is of concern for the Panel as it could lead to risks of exacerbation of an employee's problems through further exposure.

Provision of light duties and overly rigid return to work procedures appear to not help with delivering positive outcomes for individuals.

It is noted by the Panel that St John has recently implemented a program called 'Motivated Minds' and this is commended in the *Phoenix Australia Report*. The Panel understand the program to be a process to fast track the determination of liability in a workers compensation claim. Whilst possibly a positive move, in isolation it is insignificant.

7.3.10 Wellbeing and Support Team

At the time of the initial consultation, the Wellbeing and Support team had no qualified mental health professional such as a clinical psychologist employed. It is the Panel's view the composition and skills of the Wellbeing and Support Team was not adequate[109]. This was a view supported by the *Phoenix Australia Report*.

The argument made by St John that the team is a triage service directing individuals to the care and treatment they need does not stand up to clinical scrutiny. An effective triage model would have a suitably qualified mental health professional making an informed judgement on the most effective treatment for the individual. Alliances with external psychiatric services such as The Marian Centre[110] are of value provided services are appropriate for emergency service personnel and they are part of an integrated wellbeing service.

At this point it is important to make comment about the important and distinct role of a chaplain. Chaplains are an important part of care in an organisation, serving as counsellors, coaches and confidants, and offering non-denominational emotional and spiritual care. There should be no confusion between chaplaincy support and the importance of psychological care directed and provided by qualified mental health professionals. Psychological care should not be seen as a chaplaincy responsibility.

During consultations staff spoke of needing to feel a stronger connection to the Wellbeing and Support team with many noting this was due in large part to the lack of emergency service experience in the team. St John would do well to consider placing appropriately screened and trained ex frontline staff into wellbeing roles and there is precedent in many similar organisations.

Efforts being made to have members of the Wellbeing and Support team out in depots, the State Operations Centre and on road are commended.

7.3.11 Comparison of other Wellbeing Models

Staff from the wellbeing teams of both the DFES and WAPOL were involved in Panel discussions and representatives provided honest reflections into the strengths and weaknesses of their models. Both organisations use trained uniformed officers in

[109] This was the case at the time of writing this report. It is acknowledged that St John may have since employed or engaged additional clinical expertise.

[110] St John management advised the Panel of this new alliance with The Marian Centre in March 2016.

formal roles in their models, and tracking systems in place, although there are reported weaknesses.

It is the Panel's sense that these agencies seem to be doing quite well in providing support to their front line staff, although no model is perfect.

Models exist in other workforces (for example the ADF) about suicide prevention that are also worthy of examination. It would be prudent for St John to review other available models closely.

7.3.12 Coordination with other WA emergency service organisations.

A concept that came up in Panel consultations was that of a coordinated approach to emergency service wellbeing and support in which all WA based emergency service organisations access support through a single coordinated service. There would be merit in exploring this further in terms of leveraging strategies known to be effective across emergency services in a cost effective way as it would allow the development of concentrated bodies of expertise.

This was in fact a finding of the *Toll of Trauma Report* which stated '*There should be economies of scale if Western Australian emergency agencies combine to jointly deliver their welfare programs aimed at reducing staff trauma*'. The subsequent recommendation was that WAPOL, DFES and St John 'establish a formal platform to share their knowledge and experience in delivering programs to their staff and volunteers'. There was no evidence provided to the Panel that suggested this platform existed

It is the Panel's view that consideration should be given by the State to establishing a formal entity which provides wellbeing and support to all emergency service agencies. This would provide economies of scale and would help to ensure a consistency in evidence-based practice and support. If not a formalised entity then the Panel reiterates the recommendation of the *Toll of Trauma Report* for establishment of a forum for sharing knowledge and practice.

7.3.13 Impact of suicides on the workforce

Through its consultations the Panel observed a number of individuals highly traumatised by the suicides of their friends and colleagues, many months after the events. This was corroborated by findings of the Chief Psychiatrist who stated:

> *Many months on, the Reviewers found a significant level of distress, and in some cases dysfunction, in the workplaces they visited. While SJA's critical incident debriefing and offers of individual counselling are to be commended, the impact of such an event extends beyond the individual worker to the workgroup.*

A concerted strategic response is required in order to heal the immediate workplaces. At its most fundamental level, this is a core occupational safety and health obligation of St John.

7.3.14 Meeting employee expectations

It is acknowledged by the Panel that it may be difficult for any model for health and wellbeing and support to meet the personal expectations of all employees. However, there are a number of strategies which the Panel can see would maximise engagement with the wellbeing and support available and meet the needs of as many employees as possible. These include:

- Actively engaging employees directly in any changes to the model being proposed.
- Offering a wide range of services with multiple access points.
- Ensuring equitable access for all staff – country, metropolitan, communications officers etc.
- Being explicit and transparent about the evidence behind decisions to either offer or not offer particular services (for example, evidence does not support immediate debriefs post traumatic event while some employees may see this is important).

7.3.15 Support for ex-employees

As distinct from other emergency service organisations such as the armed forces, ambulance services do not appear to have any formalised system in place for recognising and supporting ex frontline employees. This may be an important issue for the State to consider more broadly in the context of its duty of care to ex-employees in high risk industries whose symptoms of psychological injury surface after their employment ceases. Method of providing assistance and support at the time of transition out of the service should be reviewed.

Finding 5

It is the view of the Panel that despite an increase in resources in the provision of wellbeing and support, St John's current approach is inadequate. It is not sufficiently evidence based and is over-reliant on a self-referral approach.

Finding 6

It is the view of the Panel that screening of the frontline workforce should occur prior to, and periodically throughout employment. This needs to be undertaken in a transparent and integrated framework of identification, follow up and treatment as required, and be mindful of the law relating to privacy and employment conditions.

Finding 7

It is the view of the Panel that implementation of a tracking system to monitor staff exposure to trauma is critical. Again, this must be within an integrated framework referred to in Finding 6.

Finding 8

It is the view of the Panel that downtime immediately following a traumatic call should be provided, if requested, as it forms a critical element to effective self-management of trauma exposure. St John advises this is current practise however the Panel heard examples from Participants of situations where it did not occur.

Finding 9

It is the view of the Panel that in addition to the continued whole of workforce approach to education, St John should reinstate the dedicated Peer Support network.

Finding 10

It is the view of the Panel that St John need to ensure that appropriately qualified mental health professionals, namely clinical psychologists with expertise in the effects of traumatic stress are employed in the Wellbeing and Support team in order to direct the provision of an adequate wellbeing service. Anything less is not adequate.

Finding 11

It is the view of the Panel that coordination and collaboration in the provision of wellbeing support with the Department of Fire and Emergency Services and WA Police should be formalised either through a separate entity, or at least through a formalised platform as recommended in the 2012 Toll of Trauma report.

Finding 12

It is the view of the Panel that the sites affected by the suicides in the St John workplace need special attention to assist with healing and overcoming the trauma they have experienced.

Finding 13

It is the view of the Panel that consideration should be given to the need for, and an appropriate model of, support for ex-frontline workers of St John.

Recommendation 4: Integrated Wellbeing and Support Strategy

It is recommended that St John develop and implement an evidence based integrated wellbeing and support strategy.

Phoenix Australia recommendation 6, 7 and 8 (Wellbeing and Support) are supported:

6. Employ qualified and experienced mental health practitioner/s on the Wellbeing and Support team.
7. Modify the content of mental health literacy and psychological first aid to be consistent with best practice approaches to these programs. Implement these programs across the organisation to ensure that staff are supported and their wellbeing monitored in an ongoing way, but particularly after a potentially traumatic event.
8. Formalise the existing avenues of support into a Wellbeing and Support Model that provides St John staff with clear guidance on the different levels of support that are available to them, based on preference and need. Ideally, a dedicated peer support team would be a part of the wellbeing and support model.

This integrated strategy should take into account the literature review findings in Recommendation 1, findings of the Chief Psychiatrist Report, Phoenix Australia Report, and Independent Oversight Panel Report, and incorporate an explicit employee engagement strategy to ensure staff input into the model.

It should incorporate requirements for screening and a tracking system.

Recommendation 5: Screening

Phoenix Australia recommendation 11 (alternative approaches) is supported:

Implement regular mental health screening of staff wellbeing combined with tailored self-care information.

- 11.1 On an annual basis, staff undertake an anonymous online mental health screen that provides feedback on wellbeing, guidance on self-care, and recommendation for appropriate level of support and professional care, where required; and
- 11.2 On a two-yearly basis, staff have a face-to-face or telephone mental health screen with a mental health practitioner. On the basis of the results, the mental health practitioner would provide feedback to the employee and make recommendations for ongoing self-care and/or mental health treatment if required.

Recommendation 6: Ownership of Wellbeing and Support Model

Chief Psychiatrist recommendation 1 is supported:

It is recommended that St John work in close partnership with staff, volunteers and their families, to review their wellbeing and support services to increase 'ownership' and address the challenges in providing such services.

Recommendation 7: Workplace Healing

Chief Psychiatrist recommendation 2 is supported:

It is recommended that SJA broaden its response to the impact of suicide and other forms of traumatic death amongst its staff and volunteers by providing proactive, ongoing support focussed on the work group, which recognises and builds upon the group's coping strategies.

Recommendation 8: State-wide Coordination

It is recommended the WA State Government give consideration to the formalised coordination of the provision of wellbeing support for emergency service personnel.

Recommendation 9: Tracking System

It is recommended a system is implemented in St John which tracks staff exposure to trauma and that this is used to flag individuals in need of proactive follow up by the Wellbeing and Support team.

Recommendation 10: Ongoing monitoring and evaluation

It is recommended St John establish an ongoing expert panel to oversee the implementation and operation of its Wellbeing and Support Model.

7.4 Operational Management, Policies and Procedures

Findings of both the *Chief Psychiatrist* and *Phoenix Australia Reports* noted deficiencies in operational management practices were contributing to organisational and workplace stressors for employees. The specific examples heard by the Panel during its consultation period corroborated this view.

Albeit from a relatively small sample size, the myriad issues shared during consultations illustrated a fair degree of poor management practices and decisions, inconsistency and lack of proper procedure in the application of policy, a perception of favouritism in rostering and other practices, and unnecessary lack of flexibility in a range of areas. These issues were reported from participants in both metropolitan and country ambulance services as well as in the State Operations Centre. The issues felt most significant by the Panel are addressed here.

Whilst bullying is covered in detail within the Organisational Culture section below, the possibility must be acknowledged that what individuals construe as bullying behaviour may in fact be manifestation of poor management style and practices and/or over-sensitised responses from poor performing employees. Regardless, this cannot be condoned.

7.4.1 Links to the military system

St John, like other ambulance services, has a long history as 'uniformed hierarchies with a command and control logic'.[2] This approach is perhaps becoming less and less relevant as the organisation moves to professional standards-based operation. A rank based hierarchy, where the paramedics are seen as bottom of the ranks, requires a very strong leadership framework as well as 'boundaries between rank-based authority and professional expertise and judgement'.[2]

This is an issue which St John, like many other ambulance services seems to be grappling with and it is contributing to the organisational culture described above. Concerted effort to develop and implement a leadership framework appropriate for a professional health organisation would be beneficial at this time; one that will optimise the role, health and welfare of paramedics and other frontline workers.

7.4.2 Performance Management

In consultations with employees, performance management was described in terms of scrutiny and discipline, with lamentations that the process was not used as a more constructive learning process. It appears to be protocol-driven appraisal rather than employing a real-life risk management and situational risk appraisal.

It is acknowledged that some individuals can find a performance management process uncomfortable and the discomfort due to individual poor performance, but the Panel is of the view that the experiences of some individuals in a St John performance management process extend well beyond discomfort.

Whilst employees talked of having support people included in discussions, it was stated in several submissions that individuals were explicitly told the support of the Wellbeing and Support team was not available to them as the Wellbeing and Support team cannot be involved in operational matters. St John has advised the Panel that Wellbeing and Support team members cannot act as support people within a performance management meeting as it would compromise their ability to provide

independent care beyond the meeting. This is perhaps an example of where clearer communication is required to employees to help them better understand their rights and entitlements and the roles of various people in the organisation.

It appears it is timely for the performance management processes of St John to be modified in the context of professionalisation of the workforce.

The link between performance deterioration and psychological dysfunction has been evidenced in literature. That is, symptoms of a person experiencing mental illness can manifest as poor performance in the workplace. There appears to be little consideration of this in St John's performance management policy and procedures and evidence through the Panel consultations indicates it is also lacking in practice. Hence a psychological assessment should be an aspect of workplace performance management in the context of the provision of appropriate psychological support.

It is also conceivable that a performance management process, particularly one that is punitive or disciplinary in nature, or generally mismanaged, may contribute genuinely to a person's stress levels.

The panel agrees with the Chief Psychiatrist that there is a need within St John for an independent review in performance management processes where a concern is raised regarding the individual's mental health. St John advised that this already exists and has been activated in the past.[111] The Panel heard evidence to the contrary where in one case, a station manager requested the pausing of a performance management process and this was refused by management.

It is important to distinguish independent oversight from union or legal representation, which is a workplace right.

Finding 14

It is the view of the Panel that training for staff moving from frontline service into management roles must be strengthened. Training for all management positions should be provided on an ongoing basis. This training should focus on the application of policies and procedures as well as appropriate management behaviours.

Finding 15

It is the view of the Panel that a revised leadership framework appropriate for St John's professional organisation is required. The Panel's view is that the tension created by an organisation in transition is contributing to issues with management and leadership capability.

[111] In St John response to Chief Psychiatrist Report.

Finding 16

It is the view of the Panel that St John's performance management framework needs to be reviewed to take into account St John's transition to professional registration of paramedics, as well as the connection between poor mental health and poor performance.

Recommendation 11: Training, Education and Support

Phoenix Australia Report recommendation 3 and 4 (Training, Education and Support) are supported:

3. Engage with mental health professionals (either internal or external) with relevant experience to provide regular and repeated workplace training for managers in how to identify signs and symptoms of stress and how to support their staff.
4. Provide initial and ongoing workplace training and mentoring for managers to ensure development and maintenance of core skill competencies for managing and supervising staff, including how to address staff issues such as bullying in a timely and appropriate manner. To ensure that skills are maintained, refresher training should be offered at least every two years.
5.

Recommendation 12: Leadership Capability Framework

It is recommended St John give consideration to the development and implementation of a leadership capability framework appropriate to a workforce with professional registration.

Recommendation 13: Performance Management

Chief Psychiatrist recommendation 4 is supported:

4. It is recommended that St John review its Performance Management process with a view to providing clear guidance on the conditions under which:
    - The process may need to be amended or suspended;
    - Expert psychological advice should be sought
    - An independent person be appointed.

Further, it is recommended St John revise its performance management policy and procedures in light of the connection between poor mental health and poor performance; and the move towards professional registration of paramedics.

7.5 Issues Specific to the Country Ambulance Service

Themes emerging from Panel consultations and documentation review indicate significant challenges in providing an effective and efficient ambulance service for rural and remote Western Australia. This is not a new issue and is a challenge faced by many community service organisations.

There was also a strong sense amongst country-based participants that St John's management does not appreciate the unique context of country sites; that systems, processes and resources are metro-centric leaving country staff and volunteers feeling second rate and under-valued.

It is the Panel's view that the current model of delivery of ambulance service in the country may be a driver behind problems of stress and dissatisfaction in this particular workforce.

7.5.1 The Volunteer Model

Reliance on the volunteer model in country areas carries increased risk to the organisation, community and volunteers themselves.

The main risks the Panel heard in its consultations related to expectations on paramedics in undertaking advanced clinical protocols with under-trained volunteers; the sense they were responsible for the psychological wellbeing of volunteers; and the impact on volunteers personally of serving their community for hours at a time, balanced with their own paid jobs and family responsibilities.

In all volunteers with whom the Panel consulted as well as paramedics who work with volunteers there is a strong feeling St John does not sufficiently value and support its volunteer workforce, in terms of wellbeing but also in training and development.

A further issue identified by the Chief Psychiatrist and with which the Panel agrees is the risks associated with volunteer recruitment practises not identifying individuals with pre-existing mental health issues and the assessment of whether they are suitable to take on ambulance officer roles. In response to this concern, St John CEO advised the Panel that approximately 30 percent of volunteer applications are not accepted. The Panel does not concur that this indicates successful or sufficient mental health screening practices.

It concerns the Panel that a significant increase in the volunteer workforce is planned in the coming decade and the current systems are inadequate for the existing volunteer workforce. The appropriateness of perpetuating the volunteer model is questioned at a time when ambulance services are moving toward professional registration.

It is strongly suggested a review of the volunteer model is undertaken in relation to the risks associated with reliance on volunteers in country areas, and consideration be given to innovative shared models with WACHS. A suggested model for country

ambulances may be to have them manned by nurses and paramedics. This would provide opportunities for a sharing of professional roles and career progression for paramedics, and would see ambulances as part of the acute care system in country hospitals.

7.5.2 Safety and Quality

Other major concerns for the Panel relate to safety and quality in terms in the context of a limited resourcing; use of second hand or outdated equipment; maintenance of advanced life skills and execution of such skills with under-trained volunteers and limited backup available; and training and development overall.

Fatigue management in any ambulance service context, but particularly the country, is very challenging. Extended periods of on-call for community paramedics, country based paramedics and also volunteers is worrying. This practice does not allow individuals to withdraw for true rest and recuperation away from the demands of the role. The absence of adequate periods of downtime may have the consequence of increasing the risk of psychological injury.

This is a significant burden for the St John organisation to carry on behalf of the WA community and it is the view of the Panel that strategic discussion with the State Government occurs in order to work towards a more sustainable model.

Finding 17

It is the view of the Panel that the current model for ambulance services in the country poses increased risk to individuals due to stressors unique to the country model. The Panel therefore believe that perpetuation of the current model for the provision of country ambulance services presents risks to the community and the State.

Finding 18

It is the view of the Panel that stringent screening of and wellbeing support for volunteer ambulance officers is critical.

Recommendation 14: Community and Country Paramedics

Phoenix Australia recommendation 9 and 10 (Community and Country Paramedics) are supported:

9. Provide initial and ongoing workplace training for paramedics who work with volunteers to ensure development and maintenance of core skill competencies for managing and supervising volunteers. To ensure that skills are maintained, refresher training should be offered at least every two years.
10. Undertake a review of community and country paramedic processes to ensure recruitment, role clarity, training and support processes adequately address the challenges of working as a country or community paramedic.

Recommendation 15: Long Term Model for Country Ambulance Services

It is recommended St John work with the State Government through the WA Country Health Service to determine a long term solution to the provision of country ambulance services to rural and remote areas of Western Australia.

This would incorporate Chief Psychiatrist recommendation 5:

It is recommended that St John in partnership with WACHS undertake a detailed review of the ambulance service in the Northern Goldfields to determine the most effective service delivery model for this region.

Recommendation 16: Volunteer recruitment to include regional assessment

Chief Psychiatrist recommendation 6 is supported:

It is recommended that St John review its volunteer recruitment process to include an assessment by regional services (possibly including reference checks, interviews and on-the-job experience) with delegation of the final decision for acceptance to regional services.

Recommendation 17: Managing Psychological Risk in Volunteers

It is recommended more stringent psychological screening of volunteers occurs as part of the recruitment process and that explicit strategies are implemented which more effectively manage exposure to trauma in volunteers.

7.6 Organisational Culture

Whilst acknowledging the relatively small sample size involved in Panel consultations, the Panel has reached the conclusion that there is an element of the culture of St John which displays aspects which can only be described as toxic and dysfunctional. A strong theme which emerged throughout the consultations and in both the *Chief Psychiatrist* and *Phoenix Australia Reports* is that St John appears to have a disciplinary culture where bullying, harassment, discrimination persist.

Those who approached the Panel displayed a distinct lack of trust in management with perceptions of lack of impartiality as well as alignments between executives, and that senior management does not care. Performance management is not seen as a positive or constructive development opportunity.

In the absence of a whole of workforce culture or staff satisfaction survey it is not possible to comment on how widespread these issues are. However, the cases discussed with the Panel were significant enough to warrant concern.

The many examples provided by St John employees in the course of Panel consultations paint a picture of an unhealthy organisational culture. It is occurring at manager to subordinate and peer to peer levels. Evidence in the *Phoenix Australia Report* identified that subordinate to manager bullying is also present in the organisation.

A recurring theme emerging throughout consultations was that staff are reluctant to come forward, to tell their stories or formalise their complaints out of fear of repercussions and losing their job.

7.6.1 Professionalisation of the workforce

Findings of a literature review conducted on behalf of the ACT Ambulance Service confirmed 'that the ambulance industry as a whole is still in a period of transition to professional recognition'.[2] It was advised to a Panel member from an external source that in Queensland, until the 1990's, paramedics were referred to as 'stretcher bearers'. Paramedics now are highly qualified professionals practicing complex clinical procedures.

Moving toward professionalisation requires shifts in organisational and management processes, practices and leadership.[2] The Panel is of the view that St John is a work in progress in this regard. Many of the issues raised in consultations relating to poor management practices and organisational culture are not uncommon in ambulance services.[2] The Panel's sense, in being fair to St John, is that they are likely symptoms of an organisation in the process of transition.

The critical issue is that this transition to professionalisation is taken into account in any strategies employed in the future to improve St John's culture, leadership capacity and management practices. It may be timely to consider professional representation of the paramedic workforce in senior management as is the case of other health

professionals in health systems (for example Chief Medical Officer and Chief Nursing and Midwifery Officer).

This will also require United Voice WA to recognise the required shift in its role in representing a professional workforce.

7.6.2 Employee Engagement

More than just communication, effective employee engagement is fundamental to healthy organisational culture.

A strong theme emerging through the consultation, and corroborated by the *Chief Psychiatrist* and *Phoenix Australia Report* was the perception of staff that employee communication and engagement is lacking.

St John advised of several mechanisms through which they attempt engagement. They also referred to new strategies being implemented including a new wellbeing and support website which will allow ongoing and continuous feedback. As this was not in place at the time of writing its Report the Panel cannot make comment on its effectiveness.

This effort is commended by the Panel but may be insufficient. The overwhelming theme arising from the Reviews and Panel consultations was that employees feel unheard and unsupported. It is important to note that this does not relate solely to the Wellbeing and Support Model, but is also about organisational and workplace issues more broadly.

7.6.3 Strategies to Improve Culture

The Panel supports the recommendation of the Chief Psychiatrist for the development of a comprehensive employee engagement strategy and is of the view this would be incorporated into a broader strategy to strengthen the St John organisational culture.

There needs to be concerted effort on improving the credibility and perceptions of management, and a distinct improvement in accountability through closing feedback loops, vastly increasing positive communications to individual staff and responding to correspondence without fail and within reasonable timeframes.

Multiple two way communication and feedback mechanisms are needed throughout the employee lifecycle, including exit interviews. A periodic staff satisfaction survey would be valuable as a means of regularly checking the sentiments amongst all staff, acting on feedback and quantifiably measuring impacts. It is the view of the Panel that any such survey and subsequent strategy should be driven with significant employee and union collaboration.

Finding 19

It is the view of the Panel that based on its consultations that the organisational culture of St John requires improvement. The long term success of St John's efforts to improve the psychological wellness of its workforce requires a culture that is genuinely nurtured from the top down, and at all levels. Critical to this is strong and effective employee engagement at all levels.

Finding 20

It is the view of the Panel that strategies to improve the organisational culture of St John must take into account the professionalisation of the workforce and St John's continuing transition to a professional organisation.

Recommendation 18: Organisational Culture and Employee Engagement

Phoenix Australia recommendation 5 (Organisational culture and employee engagement) is supported:

Undertake a review of organisational culture and employee engagement, including:

5.1 Engage relevant experts to provide specific education and training to staff throughout the organisation on identifying and addressing workplace culture issues including appropriate behaviour in resolving workplace conflict, with a particular focus on bullying; and

5.2 Arrange regular staff consultations and communications to raise matters of interest and concern to staff and encourage their input and feedback; and

5.3 Arrange specific communication and consultation strategies for regional staff to ensure region-specific issues are understood and responded to.

Chief Psychiatrist recommendation 7 is supported:

It is recommended that St John undertake the development of an Employee Engagement Strategy and Action Plan.

Recommendation 19: Staff Satisfaction Survey

It is recommended St John give consideration to implementing a system of periodic whole of workforce organisational culture/staff satisfaction survey. This would allow a systematic gathering and analysis of data, development of comprehensive action plan and measurement of success.

Recommendation 20: Conflict Management

Chief Psychiatrist recommendation 3 is supported:

It is recommended that St John investigate how to better respond to the management of conflict in the workplace, including in cases of ongoing serious conflict, using an independent skilled mediator.

7.7 Appreciation of the Legal Context

As an employer, St John operates within a legal framework which dictates responsibilities surrounding employee health and safety. A concerning weakness observed by the Panel of St John and both Reviews, is the limited reference to and understanding of the regulatory framework and obligations related to psychological risk.

It is the Panel's view that St John needs to better understand and appreciate its non-delegable responsibility for health and safety of its workforce as it relates to mental health and psychological injury. This is evident in the reliance on self-reporting of mental health issues and lack of proactive strategies such as employee screening and tracking systems.

It also appears to under-appreciate its obligation to prevent further injury of those who suffer from a mental disorder and are in the workplace. In essence, it does not define its duty of care and have an appropriate implementation strategy.

Finding 21

It is the view of the Panel that St John needs to better understand and appreciate its non-delegable responsibility for health and safety of its workforce, as it relates to mental health and psychological injury. In this context, that St John did not have active screening or tracking systems in place that are recommended by accepted clinical guidelines.

Recommendation 21: Legal Framework

It is recommended that St John undertake a comprehensive review of the legal framework as it pertains to the health and wellbeing of its workforce.

7.8 Governance, Accountability and Risk

7.8.1 External Governance

St John is a charitable, non-profit organisation contracted by the State of Western Australia to deliver the State's ambulance service. The contract is managed by the Department of Health under the oversight of the Minister for Health. Notwithstanding the contract management governance in place, because St John is not an agency of the WA government it does have relative independence, unlike DFES and WAPOL.

The Panel did not seek access to the contract held between St John and the State but discussed aspects of it with the CEO of St John. The contract does not require St John to report on the health and wellbeing on its workforce and this may be appropriate according to contracting minimum standards. As a means of improving transparency and accountability however the Panel is of the view that this should be given consideration, with periodic reports being provided to Government as part of a suite of occupational safety and health indicators.

7.8.2 Internal Accountability and Role of the Board

The Panel did not seek access to the Board of St John or any board reports throughout the review process but again, discussed aspects with the CEO.

To raise the profile and importance of psychological injury and wellness in the workforce and to introduce a stronger element of transparency and accountability it is the view of the Panel that it should be introduced as a Board meeting standing item.

A recommendation of the *Toll of Trauma Report* was that obligations surrounding psychological health are reflected in CEO performance agreements. The Panel strongly supports this action.

7.8.3 Risk Management

By its very nature as a provider of emergency health care, St John would be expected to have a low risk threshold naturally identifying all risks and ensuring adequate mitigation and monitoring strategies are in place.

It has become evident to the Panel that an important area of workforce risk, that is psychological risk, has not been adequately identified and may not therefore not be managed appropriately. This was ratified by the *Phoenix Australia Report* which found an incomplete risk register with more attention required on psychological risks in documentation such as Workers Compensation and Injury Management procedure and Risk Management Procedure. The Panel would also suggest that improving the reporting of psychological risks to the Board is required in order to raise the profile of the risk.

Finding 22

It is the view of the Panel that transparency and accountability in relation to the psychological risk and care of the ambulance service workforce could be improved by inclusion of key performance indicators in the Chief Executive Officer's performance agreement and strengthened internal and external reporting.

Finding 23

It is the view of the Panel that St John has not recognised sufficiently enough the real risk of psychological injury in its workforce. Current risk management processes, in the view of the Panel, do not adequately identify and mitigate psychological risk.

Recommendation 22: Accountability in CEO Performance Agreement

Aligned with the Toll of Trauma Report recommendation 3 it is recommended the Chief Executive Officer be made responsible for the psychological health (as a result of critical incident trauma) of St John employees and volunteers, as it relates to the work environment. This obligation should be reflected in the CEO performance agreement.

Recommendation 23: Reporting to the Board

It is recommended regular and formal reporting of psychological risk and care of the workforce to the Board of St John should be implemented.

Recommendation 24: Reporting to the State

It is recommended the contract between the State and St John incorporate agreed key performance indicators relating to report psychological risk and care of the workforce.

Recommendation 25: Systems and Documentation

Phoenix Australia recommendation 1 and 2 (Systems and documentation) are supported:

1. Review Safety and Injury Support Services (SISS) documentation (e.g., risk register, OHS responsibilities) to reflect thorough consideration of psychological as well as physical risks.
2. Develop an evaluation and continuous improvement framework for managing psychological risks.

7.9 Relationship with United Voice WA

In light of the information provided to the Panel, the relationship between St John and United Voice WA can be characterised as fractured, mistrusting, and dysfunctional. Both parties spoke of frustrations with each other and a view that the other was being neglectful of its duty of care to its employees or members as the case may be.

The Panel heard evidence from both parties that causes concern. Examples included obstruction, bullying behaviour occurring between the organisations, sensationalising or underplaying situations.

United Voice WA made a written submission to the Panel[112] which, notwithstanding some ambit claims of an industrial nature, was balanced and reasonable. The Panel was impressed with United Voice WA's awareness and clear articulation of evidence in contemporary literature of mental health risks for emergency services workforces. The Panel is of the view there is a good understanding of the issues and the intention within the United Voice WA organisation to seek the best outcome for the workforce. It appears the deterioration in the relationship between the parties has led to polarisation of the rhetoric in industrial language rather than using it as a discussion with a professional workforce about standards of practice and safety.

A critical issue the United Voice must recognise is the required shift in its role to now representing a highly professional workforce and its shared responsibility, along with St John management, of ensuring the best outcomes for this workforce.
Based on the information available to it the Panel does not support the view expressed by St John management that United Voice WA are seeking to sensationalise the issue of suicides in the workforce. It does however, support the view that some of the tactics allegedly employed by United Voice WA in attempting to highlight and seek traction on the issues on the other hand, are perhaps detrimental to the cause. As each side blatantly denies any wrongdoing it was difficult for the Panel to ascertain which, if either, party was in the wrong. Regardless, continuation of the dysfunctional relationship will only do further damage and both parties must put aside their differences and proceed in earnest for the good of the workforce.

Finding 24
It is the view of the Panel that the current relationship between St John and United Voice WA is dysfunctional and counter-productive to achieving the best outcome for the St John workforce. Both parties play an equal role in rectifying this situation.

112 United Voice agreed to waive its rights to confidentiality of its written submissions so that the Panel could reference their recommendations in this Report.

Recommendation 26: Collaboration between St John and the workforce and workforce representatives

It is recommended St John and the workforce and workforce representatives collaborate and develop a comprehensive wellbeing and support plan which is universally agreed.

7.10 Implementation of Recommendations

Much consideration has been given to the recommendations to ensure they are specific, achievable and importantly, impactful. It is the Panel's hope that St John will give its utmost consideration of the recommendations.

It is recommended that St John establish a robust approach to the consideration and action planning to address recommendations made by the Panel, *Chief Psychiatrist* and *Phoenix Australia Reviews*.

Some form of ongoing oversight involving internal, external and workforce/union representation should be considered with periodic reports provided to the Board. Further, it is recommended a formal review of progress toward addressing the issue of psychological risk and care for the St John workforce is undertaken in twelve months' time, reporting to the Board and the Director General of Health.

Recommendation 27: Implementation Oversight

It is recommended a body be established to oversee the implementation of recommendations in this Report with a formal progress report conducted in 12 months.

Acronyms

ADF	Australian Defence Force
CEO	Chief Executive Officer
DFES	Department of Fire and Emergency Services
DoH	Department of Health, Western Australia
DSM	Diagnostic and Statistical Manual of Mental Disorders
EAP	Employee Assistance Program
OSH Act	Occupational Safety and Health Act (1984), Western Australia
Panel	Independent Oversight Panel
PTSD	Post-traumatic stress disorder
SOC	State Operations Centre
ST JOHN	St John Ambulance – Western Australia
WACHS	WA Country Health Service
WAPOL	Western Australia Police

Attachment 1

St John Media Release – 10 April 2015

For the Service of Humanity

St John

MEDIA RELEASE

April 10, 2015

Independent Oversight Panel announced

St John Ambulance today announced the establishment of an Independent Oversight Panel to examine its workplace culture and the well-being of its staff and volunteers. St John Ambulance CEO, Tony Ahern, said the Panel was formed to ensure that the organisation was providing the best possible workplace environment, support and services.

The Independent Oversight Panel includes Dr Neale Fong, the former Director General of WA Health Department and current Chairman of the Ministerial Council for Suicide Prevention. Dr Fong will be supported by The Honourable Ian Taylor, the former Minister for Health and current Chairman of Rural Health Workforce Australia.

"Both of these men are well-respected and have a great deal of experience in the areas of general health, mental health and suicide prevention. Their independence, insight and understanding into what are very delicate and complicated issues will be greatly valued," said Mr Ahern.

The Panel's role will be to explore:

- The issues and performance around workplace well-being programs and support structures;
- Factors surrounding paramedic and ambulance volunteer suicides and the management of personnel affected by work-related stresses and suicide;
- The management of psychological risks in the workplace;
- Workplace culture and grievance processes, including any issues of bullying and harassment; and
- Management and operation process and protocols relating to employee engagement and employment.

"One of the other roles of the Panel is to give the organisation independent advice and recommendations about the current and former reviews, in relation to management and our processes relating to employee engagement, employment and well-being," said Mr Ahern.

The reviews identified include:

- Department of Health: Chief Psychiatrist's Review of St John Ambulance Paramedic and Volunteer Suspected Suicides;
- Australian Centre for Posttraumatic Mental Health (University of Melbourne): Review of St John Ambulance's Wellbeing and Support Services;
- Previous government and independent reviews on the operations and management of St John Ambulance; and
- Any further reviews or research programs to be commenced.

St John Ambulance Western Australia Ltd.
209 Great Eastern Highway, Belmont Western Australia | PO Box 183, Belmont Western Australia 6984
Tel 08 9334 1222 | Fax 08 9277 6662 | Email info@stjohnambulance.com.au | ABN 55 028 468 715 | ACN 165 969 406
www.stjohnambulance.com.au

As well as establishing the Independent Oversight Panel, St John Ambulance will also employ two additional chaplains who will visit on-road ambulance crews and increase the awareness about the organisation's broad range of well-being and support services.

"Whilst the overwhelming feedback from staff and volunteers about the services we provide has been very positive, there have been comments about the need for greater on-road visibility of those services," said Mr Ahern.

"In recognition of this feedback, the State Chaplain will increase the number of staff dedicated to well-being and support at St John to 10, reflecting the organisation's commitment to well-being and support resourcing."

-ends-

Media enquiries should be directed in the first instance to Dennis Bertoldo, Media and Public Relations Manager, on 9334 1237 or via dennis.bertoldo@stjohnambulance.com.au

Attachment 2

Private and Confidential

<insert name>
<insert address>
<Suburb> WA <postcode>

Dear <insert name>

Independent Oversight Panel – Private and Confidential Hearings

Thank you for registering your interest in a private and confidential hearing for the Review into Workplace Culture and Wellbeing at St John Ambulance.

An appointment has been scheduled for you for:

Date: **<insert date>**
Time: **<insert time>**
Venue: **SGIO Board Room, Leadership Centre**
Australian Institute of Management
76 Birkdale Street, Floreat (Map attached)

To assist in your preparation for the hearing, please find attached information on the private and confidential hearing processes.

Teleconference facilities are available for people requiring this service.

Please confirm you attendance or any further queries to Donelle Rivett via 0450 001 613 or info@independentoversightpanel.com.au by 28th July 2015.

Yours sincerely

Dr Neale Fong
Chairman
Independent Oversight Panel

Thank you for registering for a private and confidential hearing with the Independent Oversight Panel (Panel). This information will help answer some questions you may have prior to your private hearing with the Panel and provides a guide to the hearing process.

Private and Confidential Hearings
The information that you provide to the Panel members during your private hearing is confidential and will help the Panel members to understand the impact on staff and volunteers relating to the workplace culture and well being at St John Ambulance.
Private hearing sessions will be approximately 45 mins. Please arrive 5-10 mins early to your scheduled appointment to register your attendance at the front reception. On arrival, you will be directed to a waiting area prior to the commencement of your hearing.

During the private hearing, the session will be recorded and notes taken, however, this information will remain confidential and used for the assistance of Panel members.
If you wish, you can be accompanied by a support person. They may wait in a room close by, or they can come into the session with you.

Preparing for the Private and Confidential Hearing
Before attending the private and confidential hearing, it helps to prepare yourself and order your thoughts so that you can make the most your time with the Panel members. You may also consider your recommendations for change, in particular:

- Please let us know if you have suggestions that the Panel should consider that would improve the workplace culture and health and well-being at St John Ambulance:
- Do you have suggestions for changes to the organisation's policies and procedures?
- Is there anything that you would like us to recommend to St John Ambulance?

If you prefer, you can bring a written statement to provide to Panel members.
It is important to understand that the Panel members are not able to assist, or make a representation on your behalf to St John Ambulance for an individual issue or workplace injury/stress related issue that you may be currently facing.

Terms of Reference
As identified by the Terms of Reference, the Panel will provide independent review, oversight and consideration of work commissioned by St John Ambulance that will explore:

- The issues and performance around workplace well-being programs and support structures;
- Factors surrounding the past and recent deaths of paramedics including suicides and the management of personnel affected by work-related stresses and suicide;
- The management of psychological risks in the workplace;
- Workplace culture and grievance processes, including any issues of bullying and harassment; and
- Management and operation process and protocols relating to employee engagement and employment.

Given the Panel's remit and timelines, they will focus on identifying organisation-wide issues and make recommendations regarding improvements and best practices identified as part of the multiple reviews and will provide St John Ambulance with an independent view on management and operations relating to employee engagement, employment and well-being.

About the Panel Members

- **Dr Neale Fong** - Dr Fong was the former Director General of WA Health Department and is the current Chairman of the Ministerial Council for Suicide Prevention.
- **The Hon Ian Taylor** – Mr Taylor was a former Western Australian Minister for Health and is the current Chairman of Rural Health Workforce Australia.
- **Professor Alexander (Sandy) McFarlane** - Professor McFarlane is the Director of the University of Adelaide's Centre for Traumatic Stress Studies. Professor McFarlane's area of particular specialty has been the effects of traumatic stress and is an international expert in the field of the impact of disasters and posttraumatic stress disorder (PTSD).

Support Services

We recognise that for some people the process of participating in a private and confidential hearing and recalling some issues may be a stressful process and recommend that you seek assistance if required from your existing health professionals. Alternatively, the support telephone services for Lifeline and Beyond Blue are provided below for your convenience :

Lifeline	13 11 14	24hour telephone crisis support
Beyond Blue	1300 224 636	24 hour telephone support service

For further information

For further information, please contact Donelle Rivett, Administrator at info@independnetoversightpanel.com.au or 0450 001 613.

Attachment 3

Independent Oversight Panel - Workplace Culture and Well-Being at St John Ambulance

About the Independent Oversight Panel

As a result of concerns raised by the public on paramedic health and well-being, St John Ambulance has requested the establishment of an Independent Oversight Panel (Panel) to examine its workplace culture and the well-being of its staff and volunteers. The Panel will review issues and the performance of St John Ambulance's workplace and well-being programs and support structures, including factors surrounding the recent deaths of paramedics.

In particular, the Panel will consider the management of personnel affected by work-related stressors, and the work place culture and grievance processes within the organisation.

The Panel is aware of the research program being conducted by the Australian Centre for Posttraumatic Mental Health (University of Melbourne). The Panel will have access to the workings and final report of this program, so submissions and hearings to this Panel should focus on issues that would not have been previously presented.

The Panel will meet with St John Ambulance staff, volunteers, and other necessary stakeholders to examine the issues. Further, due to community interest, members of the public will be invited to contribute information or make submissions (either anonymously or named) to the Panel.

The Panel will provide St John Ambulance Board of Directors with a report of the Panel's findings and recommendations.

About the Panel Members

Dr Neale Fong - Dr Fong was the former Director General of WA Health Department and is the current Chairman of the Ministerial Council for Suicide Prevention.

The Hon Ian Taylor – Mr Taylor was a former Western Australian Minister for Health and is the current Chairman of Rural Health Workforce Australia.

Professor Alexander (Sandy) McFarlane - Professor McFarlane is the Director of the University of Adelaide's Centre for Traumatic Stress Studies. Professor McFarlane's area of particular specialty has been the effects of traumatic stress and is an international expert in the field of the impact of disasters and posttraumatic stress disorder (PTSD).

Terms of Reference

The Independent Oversight Panel will provide independent oversight and consideration of work commissioned by St John Ambulance that will explore:

- The issues and performance around workplace well-being programs and support structures;
- Factors surrounding the past and recent deaths of paramedics including suicides and the management of personnel affected by work-related stresses and suicide;
- The management of psychological risks in the workplace;
- Workplace culture and grievance processes, including any issues of bullying and harassment; and
- Management and operation process and protocols relating to employee engagement and employment.

Process and Method

The Panel will make recommendations regarding improvements and best practices identified as part of the multiple reviews (see below) and will provide St John Ambulance with an independent view on management and operations relating to employee engagement, employment and well-being.

The reviews identified include:

1. Department of Health: Chief Psychiatrist's Review of St John Ambulance Paramedic and Volunteer Suspected Suicides (commenced April 2015);
2. Australian Centre for Posttraumatic Mental Health (University of Melbourne): Review of St John Ambulance's Wellbeing and Support Services;
3. Previous government and independent reviews on the operations and management of St John Ambulance; and
4. Any further reviews or research programs to be commenced.

The Panel will receive confidential written submissions and hold private and confidential hearings as required, especially into areas not covered by the commissioned reviews, but related to the management of personnel affected by workplace stressors and workplace culture. Hearings will be held in neutral venues and written submissions will remain confidential.

The Panel will provide a final report to St John Ambulance at the completion of the above reviews highlighting recommendations and improvements which could be considered and undertaken by St John Ambulance.

How to Make a Written Submission

Details of a submission

To make a submission, the submitter should specify whether the matter they are raising relates to a policy, process, system, or outcome as a result of workplace culture and well-being.

Confidentiality

Submissions will be treated confidentially and all personal information provided by submitters will be handled in accordance with the *Privacy Act 1988(Cth) and Australian Privacy Principles*. Other than the information necessary for the Panel to assess the submission, the submitter's personal information (including identity and contact details) will not be disclosed.

Lodging a submission

The submission process will commence on 3 June 2015. An invitation for submissions will be advertised in *The West Australian* (Wednesday 3 June 2015 and Saturday 6 June 2015). Lodgement of submissions closes **15 July 2015**.

Postal: Independent Oversight Panel, PO Box 45, Claremont WA 6010

Email: submissions@independentoversightpanel.com.au

Private and Confidential Hearings

Details of Private and Confidential Hearings

The Independent Oversight Panel will undertake a series of private and confidential hearings to allow current and former paramedics and volunteers to speak directly with members of the Independent Oversight Panel about their experiences. These sessions will provide an opportunity for the Panel members to hear first hand the impact of workplace culture and safety at St John Ambulance.

Private and confidential hearings will be held between 10 – 14 August 2015. The hearings will be held in a venue independent of St John Ambulance.

Requesting a Private Hearing Appointment

Requests to attend a Private Hearing Appointment can be made in writing or via email to the following:

Postal: Independent Oversight Panel, PO Box 45, Claremont WA 6010

Email: info@independentoversightpanel.com.au

Further information

For further information on the Panel or processes related to the review, please contact:

info@independentoversightpanel.com.au