COMMONWEALTH OF AUSTRALIA

Proof Committee Hansard

SENATE

EDUCATION AND EMPLOYMENT REFERENCES COMMITTEE

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

(Public)

WEDNESDAY, 7 NOVEMBER 2018

CANBERRA

BY AUTHORITY OF THE SENATE

[PROOF COPY]

INTERNET

Hansard transcripts of public hearings are made available on the internet when authorised by the committee.

To search the parliamentary database, go to:

http://parlinfo.aph.gov.au

SENATE

EDUCATION AND EMPLOYMENT REFERENCES COMMITTEE

Wednesday, 7 November 2018

Members in attendance: Senators Brockman, Molan, Urquhart.

Terms of Reference for the Inquiry:

To inquire into and report on:

The role of Commonwealth, state and territory Governments in addressing the high rates of mental health conditions experienced by first responders, emergency service workers and volunteers, with particular reference to:

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

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

c. management of mental health conditions in first responder and emergency services organisations, factors that may impede adequate management of mental health within the workplace and opportunities for improvement, including:

i. reporting of mental health conditions,

ii. specialised occupational mental health support and treatment services,

iii. workers' compensation,

iv. workplace culture and management practices,

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

vi. collaboration between first responder and emergency services organisations,

vii. post-retirement mental health support services, and

viii. resource allocation; and

d. any other related matters.

WITNESSES

WITNESSES—continuing

ARNEMAN, Mr Jim, Project Officer, National Council of Ambulance Unions

CALLINAN, Mr Michael, State Councillor, New South Wales Ambulance Division, Health Services Union

FRASER, Mr Steven, Vice President and Ambulance Councillor, Health Services Union

GRAYSON, Mr Mick, State Councillor, New South Wales Ambulance Division, Health Services Union

SAVAGE, Mr Terence, North Coast Councillor, New South Wales Ambulance Division, Health Services Union

Committee met at 09:08

ACTING CHAIR (Senator Brockman): I declare open this hearing of the Senate Education and Employment References Committee inquiry into the high rates of mental health conditions experienced by first responders, emergency service workers and volunteers. I welcome you all here today. This is a public hearing, and a *Hansard* transcript of the proceedings is being made. The hearing is also being broadcast via the Australian Parliament House website.

Before the committee starts taking evidence, I remind all witnesses that, in giving evidence to the committee, they are protected by parliamentary privilege. It is unlawful for anyone to threaten or disadvantage a witness on account of evidence given to a committee. Such action may be treated by the Senate as a contempt. It is also a contempt to give false or misleading evidence to a committee. The committee generally prefers evidence to be given in public, but under the Senate's resolutions witnesses have the right to request to be heard in private session. If a witness objects to answering a question, the witness should state the ground upon which the objection is taken, and the committee will determine whether it will insist on an answer, having regard to the ground on which it is claimed. If the committee determines to insist on an answer, a witness may request that the answer be given in camera. Such a request may, of course, also be made at any other time.

I now welcome Mr Jim Arneman, from the National Council of Ambulance Unions and Mr Michael Callinan and colleagues from the Health Services Union. I understand that information on parliamentary privilege and the protection of witnesses and evidence has been provided to you. Do you have any comments to make on the capacity in which you appear?

Mr Grayson: I'm also NCAU secretary.

ACTING CHAIR: Thank you. I invite both organisations to make some opening remarks, and then we will ask you some questions.

Mr Arneman: To begin with, I'd like to thank you, Senators, for the important opportunity you've given us here to shine a light onto issues that are impacting on the mental health and wellbeing of first responders, but especially paramedics, who we obviously represent. The number and the quality of the submissions that you have received into this inquiry, I'm certain, have left you in no doubt as to the complexity of the problems that we face, the depth of feeling attached and the real and sometimes tragic human cost that is attached to these matters. Most importantly, the recommendations that you're going to make at the end of this will be very important for improving people's lives. The national council would particularly like to thank you, Senator Urquhart, for your driving of the establishment of this committee inquiry. Your compassion, your care and your concern have not gone unnoticed. We thank you for your commitment to this process.

I particularly look after mental health and wellbeing issues. The national council represents about 16,000 paramedic members across the Australian states and territories and in New Zealand. I'm also an intensive care paramedic, currently with the ACT Ambulance Service. I've had over three decades of experience in the ambulance sector. I had 22 years with New South Wales Ambulance and, since 2011, I've been working in the ACT. In June of this year, I was recognised in the Queen's Birthday honours list, with an Australian Ambulance Service Medal for distinguished service to bring about cultural change in the Ambulance Service in the ACT.

ACTING CHAIR: Congratulations.

Mr Arneman: I, like all of the gentlemen who are seated here beside me, am passionate about paramedicine and paramedics. That's why this is so important. We've all been involved in lots of advocacy over the years, on many important issues. I think over the last few days I've been reflecting as to why I've been a bit out of sorts and maybe a little bit nervous about appearing here today, in spite of the things that I've been involved with and done. I think it's because, on reflection, this is the most important thing that I have been involved in in my career in terms of bringing about meaningful change for the people that we represent but also to enable them to serve the communities that we care for in the best possible way they can.

In the last couple of days, we've received news of another colleague of ours who has apparently taken his own life. That's really put a very strong focus for me on what's happening here today. This is really personal for us. It's our workplace friends and colleagues that we're here to talk about. It's particularly personal for me. In 2014, in May, my wife, who is a paramedic, had a knife pulled on her in the back of an ambulance. She was working with a graduate student at the time, caring for her as well as for herself. She drew on all of her 15 years of experience to convince that person, who had a psychiatric injury, to exit the ambulance. She secured the ambulance and she called for help by pressing a duress button. Help didn't come. There was a breakdown in procedures. There were all sorts of problems with the response of police, and that wasn't due to the police's fault in any way. I'm raising it here because the struggle she went through is really emblematic of the struggle that a lot of our members have gone through when they end up with psychological injuries, from the breakdown in work practice and communications, to the initial difficulties of lodging her claim, to the adversarial process that she struck when she ended up in the workers compensation system, to the difficulties she had in finding relevant treatment professionals who understood first responders' issues, to the problems that she has had with rehab and making people understand her skills as a paramedic, to the difficulties she is now facing where she has had to realise that she can't come back to a career that she has loved because her treatment professionals have told her it's not in her best interests as there are too many triggers there for her to continue.

In May 2014, I felt like I had lost my wife. My wife who had been there before that time was changed forever. My son, our son, had lost the mother that he knew; the way that she interacted with him was very different after that, compared to what she had been like before. Karen lost her career, and she is not alone in that. There are many, many first responders who have been in that situation and experienced that sense of loss. But the community lost a damn fine paramedic to look after them.

That's why it's important that we do what we do here today and do it well and come up with some recommendations that provide leadership into the future. If we want an outcome out of this as a national council, it is that the Commonwealth takes a leadership position to coordinate a series of reforms that will ensure the best possible outcomes for paramedics but also for first responders nationally. To that end, that's why we've framed the recommendations that we have in terms of COAG taking a leadership role in things like setting up a first responders care network, so that we have specialised, properly accredited people who can look after the rehab, who can do the medical examinations, who can do the transition to other business—all of those sorts of things; so that we have an intergovernmental agreement on provisional liability for these psychological claims, to take the adversarial nature out of it; and so that we have a very, very close look at having presumptive legislation nationally, to take a lot of that adversarial approach out of the proceedings. We would also like the Health Workforce Principal Committee to be tasked with looking at tied Commonwealth grants into the future in perpetuity, to fund ambulance services nationally. The reason behind that call—

Senator MOLAN: Sorry—could you just say that last bit again please?

Mr Arneman: We would like the Health Workforce Principal Committee under the auspices of COAG to look at tied health funding for ambulance services nationally. At the moment, ambulance services are funded out of the general funds that are provided to the states and territories to provide health services. They are not Commonwealth funded. What that results in is that large ambulance services in particular are, in perpetuity, chasing their tails, trying to get the money and the funds that they need to staff their services. We know demand is growing at 10 per cent a year in ambulance services across the country. Why don't we have a demand based funding model that automatically supplies supplementary funding to the services to allow that to happen? From the national council's perspective, what that would do is free up all of that management capacity in those ambulance services to concentrate on the things that matter: the health and wellbeing of our staff, the business processes and providing leadership on the ground—all of those things that will make the workplaces better for the staff to operate in.

I could go on with more detail, but I'm conscious that we're running late and my colleagues probably have some opening remarks, but I'm more than happy to take questions. If there is, as I say, one thing that the national council would like to get out of these proceedings, it is some national leadership and oversight, and a coordinated approach to attacking these issues in the future.

ACTING CHAIR: Thank you very much. Mr Callinan?

Mr Callinan: I'm going to throw over to Mr Fraser, who's going to do an opening statement for you.

Mr Fraser: Thank you for having us and hearing us. Some background from us: the Health Services Union represents 2,310 paramedics and control centre staff—we mustn't forget them as emergency workers. We're currently affiliated with the National Council of Ambulance Unions, who combine to represent, nationally, around 12,000 emergency paramedics and emergency workers. The agenda identifies that there is no submission

from the HSU. We ask the committee to note that we are party to the NCAU submission. We rely on that as our paper and agree with it in total. Our delegation here today consists of me, Terry Savage, Michael Grayson and Michael Callinan. We're all operational paramedics currently working on road in ambulances. We have a total service time of 122 years between us. We, laughingly at times, describe ourselves as survivors. That is part of our black humour. We hope we can offer some information on how we did what we did, where we did it and the problems as we see them.

At the risk of being repetitive after what Jim has already put forward, we certainly support the idea of a national care network that deals with psychological injury in emergency workers, but it should be a network that's independent—because there's a large amount of mistrust when there's an employer based psychology service—and one that's actually trained in the specifics of our psychological and emotional health issues.

The majority of our members who have been through the workers compensation process find the process more damaging than the actual injury at times. It's described to us that they become more damaged by the process of making a claim. Those stories make others tend to shy away from reporting and self-reporting. One of the things for us is a lack of resources in ambulance, in particular, right across the nation. We're here from New South Wales, but, from talking to our colleagues in the NCAU, we know it's an issue right across. The lack of resources results in an overworked and overloaded workforce that is doing difficult work every day. The lack of resources often results in poor behaviour by our managers, who are themselves under the pump to reach their KPIs, which are often unrealistic and unmeetable because the resources are just so thin on the ground. Then we find that attempts at wellness and protective measures are often tick-box approaches rather than real, down-to-earth measures.

Paramedics and control centre staff face horrendous scenes every day they go to work. It's impossible not to be affected psychologically by that. We support the idea of a national law or presumptive legislation for psychological injuries in emergency workers. You can't do what we do every day and not be affected by that. After 37 years, I can tell you that's an absolute truth. Even with all the support in the world out there, there's a limit to how much exposure there can be to the type of work we do—which we love doing. We are also asking for the consideration of a superannuation preservation age of 60 years and for that to be maintained for emergency workers. It's a situation where a lot of people have put in a lifetime in this type of work and need to retire with dignity and some security.

We thank you, the committee, for the invitation to appear and we make ourselves available to offer you any further information that you need.

ACTING CHAIR: Thanks very much. We're pretty flexible as to how we handle these proceedings, so we may run a little over time, because I suspect we've all got some questions for you. From the point of view of getting to where you are now as operational ambulance officers, how much preresilience training was provided in your career path when you guys came through, and how much is provided today?

Do you see that there is any capacity to improve the level of preparatory work we do? Is there anything we can do, in terms of the pathway to being a paramedic as a career, to minimise the negative impacts and to make sure that people in very high stress jobs, like you guys and your colleagues are, have a long, successful career?

Mr Fraser: For the past?

ACTING CHAIR: I mean as it was for you guys when you came through and what's happening now.

Mr Fraser: As to when we went through, the answer's very simple: none. The words that just popped into my head then, 'Suck it up, Sweetheart,' are the approach that has been taken in the past. That is changing, and I'll ask Terry to tell you about some of the things he's done voluntarily, off his own bat, with new graduates at university.

Mr Savage: Officially: what Steve said is exactly right. I started around the same time as Steve and it was: 'There's your Gregory's street directory, and the very best of British luck.'

Voluntarily: at the moment, I go out and give a presentation to the university students. University students are predominantly our intake now, though we still have a vocational entry. I think we're the only state that has that. We're survivors, as Steve put it. I don't want to make that too emotive, but I see it as that. One of my major roles, which is also voluntary, is peer support. I was the second peer support course, in 1988. Basically, we're supposed to be contacted if someone's in a bit of strife—if they've been to a nasty accident, had a bad medical experience or whatever. To this day, that is still not working properly. We find out three, four, five days, maybe a week, later and it's really difficult to rein people back in and get them going in the correct direction. One of the things that we are doing—and there's one other person doing it in New South Wales—is going out and talking to students and giving them an idea of the real world. The feedback is amazing, because they then have some preparedness for what they're going to do.

It's not just that you're going to see a terrible car accident. Yes, it's all that sort of thing, but it's also some of the medical things. I deal with peer support people. On top of the trauma, it's some of the medical things. They grow attached to a patient for two or three years, and then all of a sudden that patient passes away. And they do take it on. I've always had a saying: 'The day you can go to work and not be affected, it's time to go and lay bricks'—because you're interested in the job and you like to help people.

One of the things I would like to see—this is my personal opinion—relates to when we get people who start on the road. They start out one on a car. In Sydney they're thrown into the four. If we get trainees in the country, they get there, they're introduced to me, and then we've got a trainee on day 1. We've had no training in having trainees. If we get a nasty job first up, which happens, we've got a trainee who is, if you're lucky, not gobsmacked. So they're already off to a bad start. They get a fantastic education—when they come out of school they've learned more than I learned in my intensive-care course 35 years ago—but they don't get any preparedness for the real world, and therein lies the trouble. We would like to see them do some time—and I realise we're strapped for staff—as third person. We're now mopping up what we've got. We could get them to spend some time as third person on the car, because we always have two operational paramedics, who could be of different levels.

It would be like getting someone straight out of school and—no offence—bringing them into your job. They have no idea of the background. You're setting them up to fail emotionally. You're probably not setting them up to fail operationally, because they're very clever and they learn the trade when they get out on the road, but there's no preparation for them. The peer support system works haphazardly. There's a communication breakdown, as I said before. We've come a long way and we've put all these things in place, but they're not coordinated and, from what Jim said, they're not working that well. At one station near me, we've got two people off over one incident which wasn't traumatic; it was medical. It was psychologically traumatic, and that was purely and simply because the car was 32 minutes away from a 28-year-old cardiac arrest. It was at a football ground, on the field. So you can imagine the pressure those people were under when they got there. And, as a result of the seven staff we had there, we've still got two people off two years down the track. That's avoidable.

ACTING CHAIR: Sorry, how long down the track?

Mr Savage: Two years down the track. It has just gone the second anniversary of his passing. I can't judge whether they're going to come back or not. But one of their return-to-work phases is to go and do paperwork at the station. So I doubt whether that person will come back. I'm not qualified to pass on that, but my gut feeling, if you like, or my operational guess is—sorry, I've taken up enough of your time.

ACTING CHAIR: No, that's great. I just wonder, Mr Arneman: do you have any comments on that prevention aspect? A lot of your recommendations are to do with the ramifications of PTSD and making sure we handle that in a better way. Is there more we can do on the front-loading side?

Mr Arneman: Absolutely. I sit on the Council of Ambulance Authorities mental health and wellbeing working group. That was put together in the last 12 months after we signed an accord with the Council of Ambulance Authorities to look at how we can coordinate best practice across a range of areas impacting mental health and wellbeing. It has only had a couple of meetings so far—it's early days—but the discussions have shown that we very much agree that we need to have a holistic approach to mental health and wellbeing. A holistic approach in our context means: prior to beginning your career; at the start of your career; in those early days when you're still finding your feet; when you're a bit more experienced and need different types of support; and, indeed, post retirement. So it's a whole continuum, if you like, of how we need to approach these things.

In regard to your specific question, that means going into the universities and actually preparing people in the universities for the sorts of things that they might come across, but also informing them about the support systems that are, hopefully, going to be in place that they can rely on and go to to deal with the stresses and strains. We've looked at what we think is best practice in the national council across the jurisdictions as they currently exist. There are some very good programs out there. There are some jurisdictions that are, off their own bat, going and talking to the universities in their states and territories and giving them a little bit of a heads-up.

There is a program in Queensland Ambulance called the Silver Lining program, which their new graduates are required to undertake as part of their induction training. It requires them to go and access a peer supporter or a psychologist as part of their training—go and have a chat to them and find out what the services are about. That serves two great purposes, and they've peer reviewed this: it gets them used to the idea that this is just normal and this is how you should go about your business, but it also takes the stress out of that so that, when the proverbials hit the fan in these sorts of jobs that Terry was referring to, you're not at a point where you can't think straight and don't know how to access these things. You have already done it and you've already established a bit of a rapport with the people you're going to talk to, and that gives you an opportunity to hopefully get the best treatment possible.

ACTING CHAIR: I do have more questions, but I am conscious my colleagues do too, so I will throw to Senator Urquhart now.

Senator URQUHART: Thank you for your opening statements. I want to address some of the issues that are in the submission put in by the NCAU. I'm happy for you guys to jump in if you need to. You've got a recommendation in there to legislate for a preservation age of 60 for first responders and emergency workers, and you talked about that. Could you talk to me a little bit about how you think that could reduce or alleviate psychological injuries in first responders? What risks does the preservation age present to the workforce, if any?

Mr Arneman: As was mentioned, it is very much about allowing people to retire with dignity—in particular people who have served long periods in a given emergency service. I know my colleagues from the Police Association who are here today and speaking later on share a similar view. The research and the evidence very clearly states—and Sam Harvey from the University of New South Wales, I think, has already presented to the committee on this—that the longer your period of exposure is, the greater the likelihood that you will develop PTSD or a psychological injury at some point. It doesn't mean everybody does, but it is an increasing risk over time. Our recommendation in this regard was about addressing that risk and giving those people who might be a bit burnt out, who are at that point where they need to get out of the organisation, the ability to do so with some dignity and with some financial security. It was also in light of the fact that there's been some discussion over recent times about increases to the retirement age, and that's going to be counterproductive because of these increased stresses and strains impacting on our people because of the nature of the work that we do.

Senator URQUHART: Do you think there are any risks associated with that preservation age? For instance, my mindset is that you're losing people with an enormous number of years of skill and ability. Is that a risk to the ambulance service or to the community?

Mr Arneman: I see it as an opportunity actually to be using people with advanced skills and experience to mentor and coach in those later years. One of the things which I liked was a paper from Griffith University in which Professor Townsend talked about reliability-seeking organisations. He was talking about changing the focus of how ambulance services set themselves up. There has been this ongoing focus on performance; it's all about response times and getting cars out there and the next job and all that—performance and productivity. He talked about changing that to these reliability-seeking organisations where we look at reliability, safety and resilience as the focus. They're not incompatible to me. If you look at reliability, safety and resilience and set that up in an organisation, you'll get the response and the performance, because you'll have happy people. That's where these experienced people have a role to play—in mentoring and coaching and bringing people along so that just gets embedded into a culture.

Senator URQUHART: In terms of the preservation age for superannuation and particularly for retirement, that is out of kilter with the current legislation for the age of retirement. There would need to be amendments, I suspect, for first responders within legislation for that to occur.

Mr Arneman: I would presume that would be the case. I'm not an expert on that area of legislation.

Senator URQUHART: In your submission you talk about poor organisational change management as a contributing factor to the psychological injuries. What do you think of the changes that could be made to improve this? Has the NCAU partnered with any first responder organisations or research institutions to seek to improve those management practices?

Mr Arneman: I did mention before that we are sitting on a joint committee on mental health and wellbeing with the Council of Ambulance Authorities. That is the main vehicle we have to formally interact with the other services at the moment, and we're looking at best-practice models there. In a word, it's about leadership. It's really about leadership in the organisations in which we serve. Lots of ambulance services at present are realising that, to their credit. We're doing a lot of work in the ACT where we've brought in a new leadership framework that is very specifically looking at the leadership capabilities and skills that we need in ambulance, which are a bit different. We have come through a command-and-control structure over the years, where it has been a bit of a quasi-semi-military set-up. We haven't developed the soft skills in our managers and people. That is not a criticism; that's just historical reality. It's not just an Australian reality; it's an international reality in ambulance. It has been recognised in Canada and elsewhere. That's really important because beyondblue in their preliminary findings in their massive national audit that they're doing at the moment have said that the impact of workplace practices and culture is as significant as any traumatic cause when it comes to mental health and wellbeing in the field. How do we address that?

Senator URQUHART: That's been a reasonably common thread throughout these hearings in various states.

Mr Arneman: Absolutely. People looking in from the outside think, 'Oh, no, it's all about trauma.' It is not; it is actually about work practices and culture.

Senator URQUHART: Yes, how people are treated.

Mr Arneman: If we can get leadership and some consistency in leadership, and if we can agree maybe on some national capabilities when it comes to leadership in EMS ambulance generally and first responders generally, I think we'll go a long way to addressing the mental health and wellbeing issues that we're talking about.

Senator URQUHART: Okay. You talked about presumptive legislation and you talked particularly about the issues that your wife has faced. I come from a trade union background. I've worked in the workers comp system for 20-odd years and I know how combative and terrible it is. We've had the Tasmanian government and the Victorian Labor government recently announcing various forms of presumptive legislation. What do you see are the next steps to seeing that accessed across the country? Do you have any suggestions on who, maybe, would form the stakeholder group for presumptive legislation?

Mr Arneman: I congratulate those governments on passing that legislation. I think we need to take a step back and ask: why do we need presumptive legislation; why have people been out there advocating for it? Quite simply, it's because of the adversarial nature particularly of independent medical examinations over the years and the exacerbation of symptoms in people. My wife went through this. I can recall taking her to a psychiatrist's appointment where she came out crying and a wreck, quite frankly, from someone who's supposed to be caring for her. And hers is not an isolated experience. Can we change that part of the process to a point where we don't need presumptive legislation? That would be the best result, from my perspective. Maybe we agree on a best-practice claims management structure for psychological injuries. Safe Work Australia has a recommended process for that, and my looking at it tells me that what they're recommending would work. I think it's a really good framework.

But, in the absence of that, I think we probably need to have a steering group at a national level to look at the need for an intergovernmental agreement on presumptive legislation, to standardise it, if that's what's going to be required, if we can't change the other parts of the system.

Senator URQUHART: A common thread, again, has been the IMEs. The independent medical examiners have certainly not been referenced with any glowing support by witnesses that we've had in this committee. In fact, people have said exactly the same thing, 'We end up worse after we've been,' and there's a bit of searching around for one that'll give a decent report to get someone off the workers comp system. That's something that needs to be looked at, and one of the bodies—I think it was the psychologists association—wasn't all that supportive of that process either. So there's definitely room for improvement.

Mr Arneman: I think there were two submissions that addressed it. The Royal Australian and New Zealand College of Psychiatrists quoted some papers that talked about the actual quantifiable damage that had been done, in several studies. But Australia21, who also presented a very good paper and, I think, some great recommendations, made the point that—you know what?—the employers have got a duty of care here under work health and safety requirements to actually make sure the people aren't damaged more out of these systems.

But there's a financial imperative here as well. They're spending public money on those insurance premiums. They should be getting what they paid for, which is proper insurance and proper care for the workers who are injured. I'm aware there are huge variations across the country on this; I should preface my comments by saying that. But, if you've got some jurisdictions that are using private insurers in those situations, they're actually, I think, sometimes more focused on their profit and on premium reduction than they are on doing what they need to do in terms of managing risk.

Senator URQUHART: I just want to go to the New South Wales guys. I actually watched a little bit of the program on the Nine network last night. You guys are on the ground. You're out there in ambos every day. I'm interested to know: is that the reality of what we're seeing? I know I did ask the question at a previous hearing about how people were selected, if you like, for that. Apparently, it was voluntary. But I'm really interested to see whether or not the public are actually getting to see a real picture of what an ambulance does.

Mr Fraser: I've watched it twice. It's sanitised, but it's not too bad. Certainly, my overall impression—and I watched it a bit cynically, thinking it was going to be sickly sweet, and it is to a degree, and that's what I mean when I say it's sanitised—is that, in general, it's actually reasonably reflective. You can sense some of the tensions and the pressures that the paramedics face. It doesn't directly show, when you get spat on and things like that, that you can't—they don't put that into that type of show. But it shows the pressure of the call takers, the pressure of the dispatchers, the pressure of the paramedics and, then, the successes and, sometimes, failures. So the show's all

right. Anecdotally, I've heard that the UK show resulted in a reduction of assaults—well, that following the UK show there was actually a reduction in reported assaults on paramedics. If that is a result of it then I'll take it. It's good. So it's not too bad.

Senator URQUHART: Yes. One of the things that I picked up with both the UK version and the Australian version is that it seems to show that paramedics do use that peer support where they talk to one another about issues when they're coming away from a job. What it doesn't show, unfortunately, is the pressure that they're under from that next level of KPIs and that sort of stuff. So there's no real reflection of that. It looks like they're out trundling along in their ambulance and having a bit of a chat and then they get a call, whereas the reality is that it could be back to back to back to back.

Mr Fraser: Yes, there are the calls: 'Can you clear? We've got another three jobs on the board. We can't cover. Can you clear?' That happens as you're rolling into the hospital. That's what I mean by 'sanitised'. It seems very relaxed. The next job comes, and they can't wait for it. It's not so much that, particularly in metropolitan Sydney. I think they show it in one episode where they have one ambulance available. That's not an uncommon occurrence, and that's why we talk about resources. You have pressure to complete an accurate EMR, which is our medical record, while they're calling you to say: 'We've got another job for you. We've got another job for you. Can you clear? Can you clear? Can you clear?'

Senator URQUHART: I have one final question for the New South Wales guys in particular. I'm interested in the regional nature. Obviously we've been to every state. In WA particularly, because it's so large, there was a lot of pressure in the regional areas, plus it's a privatised service, which is different to every other state or territory except the Northern Territory. Can you just talk to me a little bit about what you see as the pressure points for regional versus rural, maybe.

Mr Grayson: In regional areas, obviously they're quite sparse. The amount of resourcing that goes into those areas can be quite limited. You've used the ambulance metropolitan example. For a normal car accident in a metropolitan area—with two cars, normally going at 60 or 80 kilometres an hour into each other—they might have four or five resources at that job. In regional New South Wales, you will have one ambulance and two staff, for five or six people seriously injured. They're in 100-kilometre-an-hour zones. When they collide head on, the next town might be 30 or 40 minutes or an hour away. They have to wait for that. Helicopters coming from Sydney bases or Orange or anywhere else will take up to an hour-plus to get there. So you have probably two staff sitting there, basically dealing with horrific injuries. Some of those people may actually pass away whilst you're attending that job. Again, that becomes quite emotional for the other people there. You've got to do the best for the most people, so again that becomes a decision where all of a sudden that's it; it's all over. A blanket goes over someone. That's confronting for the people that are standing there, the bystanders trying to help you. They say 'He's only young.' We say, 'Mate, we don't have the resources to do this job.'

Senator URQUHART: In terms of resourcing, one of the things that we heard, particularly in WA, was that there might be one full-time paramedic and then community or volunteers. Is that the same situation in New South Wales in regional areas?

Mr Grayson: Not for the majority. We do have some volunteer stations. We have what we call community first responders. We also have some volunteer ambulance officers in some very small communities out at the back of western New South Wales, in pretty isolated areas. Generally, as I said, the CFR network is utilised from other volunteer organisations: the RFS, the fire brigade and the VRA. They become a community first responder for ambulance. They're given some basic training in first aid and then basically, as I said, they rely on the paramedics coming from the next neighbouring towns to provide that access. In an area where we've got a CFR network, you can hear them waiting for the ambulance to get there. Their tone starts to go up and gets elevated as they're passing messages if someone's really crook. You can hear it coming before you even get there. That's what's occurring at the job. Obviously, that starts to heighten people's responses. Again, that's when people are sometimes pushing the limits to get to the jobs, because they've got further to go. They're trying to help their mate. Again, paramedics are very good at dealing with that and sort of holding it. That's generally why you see that when paramedics get out at jobs they don't run. It's to try to bring that calming, 'Everything's controlled, and we're going to do this in a reasonable time' thing. That's part of it, because, again, we've got to take control of an uncontrollable situation, where everyone else might be panicking. That's part of the pressure that we take on to try to deal with not just the patient but collectively what's happening on the scene.

Senator URQUHART: Fantastic. I thank them for their 122 years of service.

ACTING CHAIR: Absolutely!

Senator URQUHART: I may have more questions, but I'll put them on notice.

Senator MOLAN: I have some understanding of what you've been through; I used to fly the rescue helicopters in three states in my spare time, so I saw what you guys do and what you do is fantastic. I've also dealt with the Department of Veterans' Affairs over many years—not necessarily on my own behalf but on others' behalf—so I understand that. I see the changes that are occurring there—extraordinary changes that are occurring there—as a result of problems similar to yours. It's in the output, not in the way that you got there. I see that. I'd love to hear your views on why you think the Commonwealth can do it any better than the states. Jim, you're asking us to have a coordinating role at the Commonwealth level, and we seem to be taking on more and more. The states are closer to it; why don't the states do it?

Mr Arneman: It's a very good question, and I'll give you an analogy. On 1 December, paramedics are going to be recognised under the national registration scheme for the first time—as registered paramedics. It's taken 10 years to get to that point. It probably would have taken another 10 years or never happened at all if we'd been waiting for the states to take a coordinating role. Now, that was about basic patient safety and delivering the best possible accredited care in a consistent fashion to everybody across the country, and it took 10 years. If we couldn't get that sort of coordination on that issue in 10 years, we've got no chance on these issues. Frankly, it's because we've got the difference between the states and territories. Some, as senators identified, are private entities, and we believe we need some overarching leadership and compelling of those organisations to bring in some national standards to enable that to happen.

We're working, from our perspective, on the committee with the Council of Ambulance Authorities to push changes and to get things happening, but they're not mandatory and enforceable at that level. We believe it would be a good thing if we had some Commonwealth oversight of those processes. One of the things that could be done to enable that to happen would be accreditation of ambulance services at a Commonwealth level. There is no current accreditation of ambulance services. Health services generally—hospitals and all those things—are accredited, and there are national frameworks to allow that to happen. It doesn't happen in ambulance. So in our view, there is a vehicle that could be used to kick-start this process.

Senator MOLAN: You're pushing it to COAG, and that's good, but it does concern me that we're moving that accreditation away. I see in other areas of the medical profession that organisations like the HSU or your organisation set standards and then they're accepted by others. It just terrifies me to think that we're pulling more up to the state level and further away from the cars on the road.

Mr Arneman: I think that as long as we've got broad based representation on whatever body ends up coordinating those things then it will be a model that'll work well. We did have that cooperation with the stakeholder reference groups with the national registration push over the last few years. Indeed, I think it was achieved because groups like the national council stood shoulder-to-shoulder with the CAA and said, 'This is a good thing for us, it's good for our members and it's a good thing, most importantly, for the public that we look after; let's do it.' That's where we're coming from with this.

Senator MOLAN: I think there are 2,310 paramedics in the union. Do you believe just about every paramedic is represented by HSU?

Mr Fraser: The large proportion in New South Wales. I think we have around 3,000 paramedics in New South Wales ambulance, and we know we have membership of 2,310.

ACTING CHAIR: Thank you very much for your service and thanks very much for appearing today. We appreciate it. Unfortunately, we do have a very full agenda so we'll have to move on. Thank you once again.

BARRATT, Mr Paul, Chair, Australia21

PALMER, Mr Michael, Director Emeritus, Australia21

STEPHENS, Ms Lyn, Director, Australia21

Evidence from Mr Palmer was taken via teleconference—

[09:54]

ACTING CHAIR: I now welcome representatives from Australia21. I understand that information on parliamentary privilege and the protection of witnesses and evidence has been provided to you. Who was going to put their hand up to make the opening statement? Mr Barratt?

Mr Barratt: I will.

ACTING CHAIR: Great. Go ahead, and then we'll ask you some questions.

Mr Barratt: My colleagues may have some introductory remarks they want to make as well, but I'll start. Thank you for the opportunity to appear before the committee today. We've made a submission to the committee and provided a copy of the Australia21 FearLess Outreach report *When helping hurts: PTSD in first responders*. The money to undertake this work was provided by the Australian Federal Police, Victoria Police and Northern Territory Police, Fire and Emergency Services. With these three stakeholders, we were able to capture the operational circumstances that arise from the federal and international jurisdiction of the AFP, the large metropolitan high-population responsibilities of Victoria Police, and the remote area and vast distance challenges facing the Northern Territory. Other police organisations participated, as did ambulance, fire and State Emergency Service organisations from several jurisdictions.

The roundtable we held was unique in that it brought into the one real-time conversation, under the Chatham House Rule, people with lived experience; command-level personnel; professionals with organisational responsibility for the health and wellbeing of first responders and their counterparts from Defence; members of representative bodies like police associations; and other qualified professionals like academics and consultants to first responder organisations. The roundtable provided a genuine opportunity for past and present members with lived experience to share the reality of their journeys and the quality of the support they received with the roundtable participants and for senior managers and executives, as well as health professionals, to respond or comment. The outcomes from what was a positive and uplifting exchange and interaction were invaluable and are at the heart of the report's recommendations and findings.

In running this exercise, we retained full editorial control of the report. We said we'd take everybody's views into account but it was going to be our report. But we consulted participants fully in the drafting of the report to ensure their views were represented accurately and to capture any afterthoughts. We received a lot of helpful feedback, most if not all of which we took on board, and no-one sought to intervene in our findings.

In drawing up the report, we sought to address structural issues as well as to provide conclusions about the management and treatment of those individuals who are unfortunate enough to suffer from post-traumatic stress as a result of the work they do and the risks they take on behalf of the wider community. The exercise brought home to us the importance of providing impacted personnel with the opportunity to tell their stories in a safe environment. It may be that my colleagues wish to add something. We would, of course, be happy to answer any questions you have.

ACTING CHAIR: Great. Ms Stephens, did you have something to add?

Ms Stephens: Yes. I think this report may be useful to you because it ranges from the nitty-gritty right up to the whole-of-system approach. You've obviously heard a lot about that over the last few months, but I think there are probably a number of points that really struck me as a participant in this process. One was that I think we need to raise community awareness of the huge debt we owe first responders and our obligation to look after them. I think this is really the source of political will for change. The community needs these people, and it needs them to be well and well looked after.

Our report focused on PTSD, which is one of the major mental health issues in this field, and I think there needs to be a change of mindset in organisations and the community. Trauma-related stress is intrinsic to the work of first responders, and it's a standard workplace health and safety risk that needs to be mitigated and managed. The challenge, of course, is to manage that risk while still delivering what the community wants.

A third point that I really noticed was that there needs to be much improvement in the standard of care offered. As a former counsellor myself, I was horrified to hear about the standards of care that were often offered from the helping professions. There are now quite clear clinical guidelines and evidence based approaches, but we heard

that, in one state where an audit was conducted, 50 per cent of people were not receiving evidence based care. That is not good enough.

The other thing is that there are now emerging standards around how organisations should deal with this. We need to promote those and make sure that organisations are actually following good practice and sharing it across jurisdictions.

Finally, I do think there is probably a place for a national framework supported by the Commonwealth. There is a need for better epidemiological studies and a coordinating function across PTSD in first-responder organisations. That is my statement.

ACTING CHAIR: Excellent. Thank you. Mr Palmer, did you have anything to add?

Mr Palmer: Just a couple of very short comments, if I may. I fully endorse everything Lyn has just said, and she has hit most of the nails, frankly, firmly on the head. A couple of really important challenges at the government level are to do everything we can to ensure that government leaders and government members, as well as leaders of the organisations concerned, the first-responder organisations generally, have the best possible understanding of the reality of the marketplace in which their people operate. From my own personal experience, and from the roundtable itself and the feedback we had during the course of that and since that time, it clearly is obvious to me that—although, obviously, we understand the job we do—there is not really the level of understanding there should be of exactly what's entailed with that as to the level and degree of stress that we expect our people to operate under. The fact is: there is a public expectation and a government expectation and an organisational expectation generally that our people will run towards the danger when it occurs. Wherever they are needed, that's where they'll go. That is what they are trained for. This is the job we do. It is what attracts people to it. But we underestimate, I think, the danger, the damage and the stress that goes with that. That is part of the reason for the culture then that flows within the organisations and impacts on people who do suffer PTSD or similar mental health or trauma related problems in the workplace. We've got to change that culture. The only way we will do that is to raise the level of understanding so that we create a culture that understands that this is not different from a rugby league professional pulling a hamstring or doing an ACL—it is part of the price for the work you do, and it shouldn't impact on careers, and there should not be any stigma associated with the fact that it impacts on people from time to time. I think that's a real challenge.

There are two other things that Lyn mentioned that I think are critical. One is the quality of counsellors. In my experience, we don't have enough counsellors who have credibility. They may have the technical skills, but, unless they have the credibility with the people they are counselling, the counselling process can in fact be counterproductive. The other is the critical importance of us, first-responder organisations, getting better at the front end of it, the early warning signs, and early detection and better management of those early warning signs. How do we deal with that? How do we ensure it doesn't get worse? How do we try to maintain the health of people who are impacted by severe stress in a range of circumstances? Thank you.

ACTING CHAIR: Great. Thank you very much. Just a quick question from me to start, and I'm not sure who is best to direct this to, so I will just throw it open to all of you: how much quality research in this space is there, and how much is yet to be done? Do we strongly understand what we're dealing with? Do we know what works, in terms of treatment? Do we know what works in terms of preparing people for these types of jobs? Is it just not being applied, or do we actually need to do more fundamental research to work out what actually works and what does not?

Mr Barratt: I'll give you a by-and-large answer to that, and then I'll ask Lyn to give a higher quality answer to it. My by-and-large answer is that I think there's some very high-quality research going on in a couple of institutions in Australia, and the best treatment is very good, but, under what we currently know about the condition, only about a third of people are what you might describe as cured; for another third, life becomes manageable but they are still affected; and the other third are completely refractory to treatment—they don't benefit at all. That says to me that we don't know enough and that we've got a lot more we need to find out so that we shift all those percentages to the right, if you like, more in the direction of full recovery or getting back to a normal kind of life and getting people out of that last basket. So there's certainly a big research job to be done, I think.

ACTING CHAIR: Ms Stephens?

Ms Stephens: Yes, I think there's quite strong evidence based research now to support a couple of good treatments, which are—you've probably heard this—cognitive based therapy and EMDR, the eye movement therapy, which appear to work if they're applied correctly. My point earlier on is that a lot of people who should be in a position to provide this sort of treatment don't know about it or are not using it. The other point that was

made is that this can be quite a difficult condition to diagnose. A lot of GPs, who may be the first port of call, are not well trained. So I think there's a need not so much for more research in that area but for research into how to get that information out and into the workforce and into the helping professions. It may be that the AMA and the Psychological Society have a role to play in really making that happen.

ACTING CHAIR: How about in the preparations—in building resilience or putting things in place immediately following a particularly traumatic episode to stop the negative pathways being laid down in the brain?

Ms Stephens: I think there's a lot of practice experience in this area, but I was just reading this morning, in fact, that Black Dog is saying that there should be a lot more research in this area: what are the best things to do to prepare people? Is it good practice to be checking in on people all the time, or can this in fact even be counterproductive? The experience in the eighties was that debriefing was fantastic after an event, and that has been proven to be quite counterindicated. So I think we have to be careful and keep that research into practice continuing.

Again, there's quite a lot of practice experience. You've probably heard about the Queensland Ambulance Service, which came out as a striking example in our roundtable of a group that's actually got a whole-of-system approach from beginning to end and also a very integrated system. It's no good having really good treatment options if no-one can ever get to them because the managers never refer them. It's no good having really good preparation if there are not good treatment options. So I think there's some organisational work to be done as well on how you make those changes happen. How do you bring this in so that it becomes a normal way of working in these organisations?

I think there is also a lot of research to be done in the cases that are refractory to treatment. As Paul mentioned, a third of people will respond to treatment, a third may get a little bit better and a third are left with their symptoms. So there's certainly research to be done there.

ACTING CHAIR: Thank you.

Senator URQUHART: In relation to your roundtable about 18 months ago, have there been any further conversations? How are you keeping them going, and have you seen any changes in approaches by any of the first-responder organisations since that roundtable?

Mr Barratt: I think so and I hope so. Certainly it was a long time writing up the report, I have to say. We've ended up with just about 100 typed A4 pages, and we were consulting everybody all the way through. We had the formal release about the middle of this year. It was very well received by the three organisations that sponsored it, and it is my belief that they are looking at this as a way of improving it, and that was our aim. It was not to say, 'Here's the magic bullet that fixes everything.' It was to say, 'Well, here's what we took out of that roundtable,' and for each individual organisation to say, 'Pick up what ideas you think you will be valuable for you out of this and implement them in your own'—

Senator URQUHART: Is there an intention to get that group back together now the report's been released and they have had some time to absorb it?

Mr Barratt: We haven't made a move. We are actually planning to extend our work into other areas of PTSD, but we are not, so far, doing more in the first responder space, although I think some of the subject we want to tackle would certainly involve police in particular in follow-up work. We certainly want to build on what we've done. We think we've written a valuable document, and we don't want to just put it on the shelves and move on to something else.

Senator URQUHART: No, that would be a shame, and that's, unfortunately, what happens to a lot of documents. Mr Palmer, you talked about changing culture, and we've heard at all the public hearings and also in countless submissions about the push by many senior leaders in first responder organisations to improve workplace culture. We've had people from the top of organisations saying, 'We need to fix the culture.' Nevertheless, we keep hearing that it's not improving fast enough. So I'm just interested: from your point of view, what are the impediments to improving workplace culture and how would you actually remedy them? I'm happy for anyone to answer, but I just threw it to Mr Palmer because he raised the issue.

Ms Stephens: Perhaps we will get Mick to comment first.

ACTING CHAIR: Go ahead, Mr Palmer.

Senator URQUHART: Maybe we've lost him through that storm.

ACTING CHAIR: Have we lost him?

Senator URQUHART: Okay, go for your life. It's yours.

Mr Barratt: We had the evidence of the foundation just in the room, where we had people at the operational level speaking very frankly and command-level people not batting an eyelid. They were contributing constructively rather than defensively to the conversation.

Senator URQUHART: Yes.

Mr Barratt: But, in relation to the content of the change that's required, there was discussion about stigma associated with having a mental health condition, and there was also a discussion to the effect that we've got to get away from that notion and just get across the more positive notion that this is an occupational health and safety hazard of doing this kind of work. This kind of response to a horrifying experience is your brain reacting normally to something. As one senior police officer commented, it's a sign you're not a psychopath. One of the big requirements for something that gives you a better prospect of successful treatment is very early intervention, and one of the big impediments to early intervention is the fear that this is going to have an impact on your job. You heard the gentleman from the ambulance saying that, 'Suck it up, sweetheart,' was the attitude. I think that in that room we had a very sincere view that people have to be able to talk about this in the workplace. A comment was made that, until the senior sergeants take it on board, we're not going to get anywhere. They weren't saying middle management is a blocker, but they were saying that basically, whatever fine words you get from top management, unless the station sergeant or someone actually is on board with this—

Senator URQUHART: That's really what I'm referring to. That's where I've noticed that the blockages are.

Mr Barratt: Yes. It's not going to happen.

Senator URQUHART: So what do we need to do?

Mr Barratt: I'm not putting that in a negative way. I'm just saying you'll know you're making progress when—

Senator URQUHART: Yes, but what do we need to do to make that progress? That's the question I'm asking.

Mr Barratt: Just keep working at it, I think.

Senator URQUHART: I've got some other questions. I'll just keep going through. In your submission, you say that the management needs to address some framework issues such as better protection for first responders from legal proceedings and media intrusions. So can you talk a little bit about how you see that being implemented in practice and what effect that could have on mitigating psychological injury to first responders.

Mr Barratt: This is about managing the risk that we recognise exists there. The first thing is for people to know what they're getting themselves into. So we say it should be part of your training. Part of it's a screening issue: is this job the right job for you? But then it's what to look out for: what are the signs that you ought to be talking to somebody and seeking a bit of help?

There is just the confidence that comes from knowing how to manage yourself—briefing your family and friends on what they ought to be looking for. That's part of the normalisation: just to go along and have a conversation with somebody about that. And maybe you need regular interviews with the psychology and wellbeing people so it's not a threshold issue of, 'Do I go and see the organisational psychologist?' You just see them every couple of months for them to ask, 'How are you going?' They'll have a few questions they'll want to ask that will give them a sign as to whether you're starting to struggle. I think that a lot can be done at the front end, just to reduce the risk by having people seek a bit of help before it starts to take hold.

Senator URQUHART: In your submission you also called for a national system for collecting and sharing information and data. Could you take us through how you think this would improve outcomes, particularly for first responders?

Mr Barratt: It's simply by having the most up-to-date information available nationally, in one place. I think there is a lot of room for organisations retaining their autonomy but also having a national framework where their experience is fed into the database and the data about the experience of others is accessible to them—and available in standardised form. Lyn, you might want to comment on that?

Ms Stephens: I think that's another way for the committee to actually monitor what's happening. Our experience has been that there has started to be a little bit of cross-jurisdiction sharing, say, among ambulance services. But there is a lot to learn from ambulance and police together, or ambulance and firies together. It's that kind of sharing. Again, the Queensland Ambulance Service has been very generous in sharing its system with others, so don't reinvent the wheel; adapt the wheel. There is a lot of really good work happening here, but we need to bring it together to maximise its impact.

Senator URQUHART: I agree. We've heard so many good examples and evidence from different organisations, but others seem not to know about it when you move over a state border or whatever.

Ms Stephens: Yes.

Senator URQUHART: You're saying that it needs to be a national system?

Ms Stephens: Yes. I think, also, that's the only way it will become a real community priority, and we need the community behind this.

Mr Barratt: We found it enormously helpful to have Defence Health and the head of the Army Psychology Corps at the meeting, because there were discussions about things where Defence takes quite a different approach—and I would guess a bad one! Quite a lot of organisations have someone to whom you are referred if you start to need help, and sometimes this is an outsourced agency that you are referred to for help. The response by Defence was, 'When someone is getting that kind of trouble it's a job for their commanding officer to deal with them.' Their immediate commander and the commander of the unit deal with it; they don't refer them to somebody else to deal with it. Sharing that kind of information at a strategic level around the table is a very valuable mechanism.

Ms Stephens: Yes, because they may not necessarily agree that it's right for them but at least they're being exposed to a different way of looking at the whole thing.

ACTING CHAIR: Senator Patrick, did you have any questions?

Senator PATRICK: No, because I was late I will just read the *Hansard* and put questions on notice.

Senator MOLAN: Mr Barratt, you mentioned that the ambulance authorities saw the results of your roundtable. Did you get no reaction out of them, even from the middle of this year until now?

Mr Barratt: No, we haven't had anything.

Senator MOLAN: Right. And you mentioned the role of the senior sergeants, and I'm sure that Mr Palmer, with his experience, would know how to put this better than I could. It does strike me that, whatever we do—and we found this in the military—it must still start at the top, and the measure of success is that the senior sergeant equivalents in the ambulance station or in the police station do the actual activities. You were making a point about military commanders retaining responsibility—most of the military commanders have lived experience of this. It's so easy just to boot someone out and send them to the psych, but you've got to own them because they're the people that you love and they're the people that you work with. Did that come out of the roundtable at all?

Mr Barratt: Yes, I think so. The very important thing about those senior middle managers was, for example, in the context of someone returning to work after being off, after being treated for PTSD, some of them said, 'I wouldn't know how to handle them.' It was very clear from some of the people with lived experience that they were assigned to someone who didn't know how to handle them. Everyone will come face to face with this situation sooner or later. It's got to be part of the in-service training that this is how you handle people who are returning to work. They are your responsibility, and your getting them back into normal operations is part of the treatment.

Senator MOLAN: Correct.

Mr Barratt: So there are some very important issues to be worked through at the level at which organisational policy is absolutely implemented—that's at the point where people manage frontline personnel.

Senator MOLAN: And that was certainly the experience of abuse of women in the military, in that the senior sirs subjected themselves to the stories of those abused and understood it better and could then lead better in that respect.

Ms Stephens: Can I just add a comment to that, which I think is really important.

Senator MOLAN: Absolutely.

Ms Stephens: Again, with Queensland Ambulance Service, they not only train at the beginning; they train their managers in dealing with this issue. One of the experiences that they had when they started to train their managers about how to look after staff is that managers had no idea that the support systems were there for them as well. By that intervention, their own managers had a 350 per cent increase in contacting the support service, and that was often to say, 'Look, this guy has come to me and I don't know what to do,' and then they got some advice. So I think it's having those interventions at the right place. It's great to have the leadership say the right things, but, if people at this level don't have the skills and don't have the support to look after staff, it just won't happen.

ACTING CHAIR: How long has the Queensland service been taking this approach?

Ms Stephens: It's actually been developing this system for 20 years. So it obviously wasn't perfect in the beginning—and it's still not perfect, but they—

Senator MOLAN: Ms Stephens, if Queenslanders can do it, then what we don't want, in my view, is for the Commonwealth to take it all over. By all means, as we do in a thousand different areas, set the standards and set the accreditation, but we don't want to be running the services, do we?

Ms Stephens: I'm not asking the Commonwealth to manage.

Senator MOLAN: Good, thank you.

Ms Stephens: I'm asking the Commonwealth to provide a policy framework and a national approach and national support for this.

ACTING CHAIR: Thank you very much for appearing today. We really do appreciate it.

Senator MOLAN: And is that Mr Mick Palmer from the AFP?

Ms Stephens: Well, it was!

Senator MOLAN: I'm sorry—he has gone.

Ms Stephens: And it is a great shame that you didn't have his contribution, because it's very valuable.

Senator MOLAN: Did he actually chair the roundtable?

Ms Stephens: Yes.

ACTING CHAIR: We thought we had him still on the line; I'm not sure what's happened there. That's technology—even old-school technology!

McKENZIE, Mr James, Acting General Manager, Claims Management Group, Comcare

NAPIER, Mr Justin, General Manager, Regulatory Operations Group, Comcare

TAYLOR, Ms Jennifer, Chief Executive Officer, Comcare

[10:24]

ACTING CHAIR: I welcome representatives from Comcare. I understand that information on parliamentary privilege and the protection of witnesses and evidence has been provided to you. Ms Taylor, do you have any opening remarks? Then we'll ask you some questions.

Ms Taylor: My opening remarks are, perhaps, aimed at helping to clarify—and help the committee with—who is in the Comcare scheme. It's sometimes very convoluted and complex, because we are the workers' compensation insurer for the Australian government agencies and the ACT government. We're the work health and safety regulator for all of those government agencies, plus the Defence Force and also a number of self-insured licensees. We aren't the workers' compensation insurer for the Defence Force, of course, so there's complexity in there.

Perhaps to narrow that further, in looking at the first responder-type agencies that we are responsible for in terms of workers' compensation—and I can then go to the occupations—the ACT Emergency Services Agency, Airservices Australia and the AFP are the agencies that would fall under that umbrella; and the occupations are ambulance officer, emergency service worker, firefighter, fire and emergency worker, intensive care ambulance paramedic and police officer. That might help the committee, hopefully.

ACTING CHAIR: Great. Did either of you gentlemen have anything you wish to add?

Mr McKenzie: No.

ACTING CHAIR: Great. Thank you very much, Ms Taylor. We've heard about the adversarial nature of workers' compensation claims. Would you have any comments on how you see the system has evolved over time? Do you think we are getting better in that respect? Would you characterise it that way? If not, why not? Why do we have this, perhaps, different perspective from the emergency services community? I would appreciate your comments with regard to that adversarial nature of the system.

Ms Taylor: Certainly. That has come through in a number of the submissions that I've read and gone through. Over the last few years we've been working, particularly with the AFP, on processes to improve our claims processing services and our claims management. When there is an injury, what we require is a claim. For a claim, we have a claim form, a statement from the employee, a statement from the employer and a diagnosis from an appropriately qualified medical practitioner. What we've tried to put in place with the AFP is a streamlined process—or a fast track, if you like. If we have all of those things and the statement from the employer concurs with the employee—'Yes, they were at work. Yes, this happened,' or 'This is their service, et cetera. Yes, they were exposed to whatever'; and I'm talking particularly about psychological claims here—then that all comes to us. We will process it and go through it, hopefully, in a fast-track way. Have we been entirely successful in that? No. Can we improve and keep improving? Yes. And we continue to talk with the AFP, particularly.

In the case of the ACT government, until recently we have had collocation of our claims managers and the rehabilitation case managers, working closely together around claims. We're not the rehabilitation authority—that's the individual employer—so we've been looking at ways to make that service a bit more streamlined.

One of the issues that is evident from looking at our stats, though, is the time it takes for a claim to get to us. Our statistics show that the longer it takes, the more likely the person is not to return to work quickly. There are various early intervention programs, particularly in psychological injury, that individual employers have in place. So perhaps that's not as crucial, but they aren't in place in all organisations. Of course, delays in people identifying that they have an illness or injury, getting treatment and then going through the process are absolutely crucial—that all that happens early. We often don't have that visibility for an early intervention.

ACTING CHAIR: With something like PTSD, where, obviously, it can be cumulative and take a long time to manifest itself in particularly negative ways, how does Comcare approach issues like that? Do you have exactly the same process or do you take a different approach?

Ms Taylor: In relation to PTSD—and I'll get Mr McKenzie to talk in detail about it—we still have the common things that we need in dealing with that claim. So there are the claim form, the statements from both the employer and the employee and the diagnosis. Also, in looking at treatment plans and return-to-work plans we make use of our clinical panel, which is made up of specialists and, in this case, psychologists and psychiatrists. They help us in assessing if that's an appropriate and right treatment for that particular person at that time.

So there are some common things that we need to start with. But in looking at what we've been doing particularly with the AFP, which, as I said, has the largest number of PTSD claims, we've looked to fast-track those to make sure that the care is being provided. I'll ask Mr McKenzie if he wishes to add anything to that.

Mr McKenzie: Thanks. I will just reiterate the fast-track process for PTSD claims. For operational AFP officers, that involves the acceptance of the claim without the need for an independent medical examination where there is a diagnosis supported by the treating psychiatrist. In some cases we receive the claims with that information from the treating psychiatrist, but, still, in other cases we're not getting that at the moment. However, I think that where we do have that right information up-front we're able to fast-track the acceptance of the claim and without the need for that independent medical examination.

ACTING CHAIR: So you will accept an existing diagnosis without the need for an independent verification? Do I have that right?

Mr McKenzie: Yes, where there is a supporting diagnosis from a treating psychiatrist.

ACTING CHAIR: Okay.

Senator MOLAN: Ms Taylor, I wonder if you're aware of the changes within DVA's approach to roughly the same problem? It goes something like this: anyone who puts their hand up gets a degree of treatment for PTSD going into the future. The claims have come down from something like 122 days to 33 days over the last couple of years. If someone's claim is going to take a long period of time then they're paid the claim now and, depending on whether the claim is found to be legitimate in a period of time, the money is balanced off against that.

You are spending taxpayers' money and you need to be careful with taxpayers' money, but do you have an equivalent of those changes within Comcare? Or do you see the possibility of doing similar things?

Ms Taylor: I'm aware of the changes in DVA. I also sit on the Military Rehabilitation Compensation Commission. Their system and legislation are very different, so they've implemented things like straight-through processing and non-liability health care. There is the white card, for example, which, particularly for psychological injuries, is almost independent of the claim. It's allowed the provision of payment for treatment even without a claim. Our legislation allows us only to make payments where there is an accepted claim, so we don't have the ability as Comcare to provide that early intervention treatment. Employers do, and a number of employers have the ability and have in place early intervention programs because they have the very close relationship with the individual as their employer. A number of agencies do have an early intervention program not only for physical injuries. It might be that they will pay for three physio visits et cetera. But there is access to psychological treatment as well.

Senator MOLAN: If your legislation could be changed, would you see that as an advantage in the way that Comcare was able to handle these things?

Ms Taylor: I won't comment on government policy or proffer an opinion, but there was legislation introduced into parliament a year or so ago that actually provided for that amount of money for the almost non-liability health care but those changes haven't passed. That's probably, in terms of policy questions, a question for the Department for Jobs and Small Business, who are the policy owners. We generally don't comment on policy.

Senator MOLAN: You manage risk, obviously, by claims, employer statements and then doctors' reports. Do you see a significant amount of duplicity in claims being made, or is it good?

Ms Taylor: It is very rare, I would say. There are some that we will question and about which we will seek further evidence of the connection to employment as a result of that injury. There are also exclusionary provisions in the legislation that go to an injury arising out of reasonable administrative action taken in a reasonable manner, but very few claims are absolutely duplicitous or false.

Senator MOLAN: Thank you.

ACTING CHAIR: Senator Urquhart.

Senator URQUHART: I want to go to the Australian National Audit Office report. It noted that Comcare more than halved processing times for reaching a determination for accepting psychological injury claims between 2007-08 and 2016-17. That went from 125 days to 54 despite an increase in the number of claims. The claims went up from 11 to 35. Can you provide updated figures for 2017-18?

Ms Taylor: Yes, I can. In relation to AFP, I think I've got every stat other than the processing times, but I can take that on notice.

Senator URQUHART: Okay. What about the fastest approval and slowest approval? Can you provide that?

Mr McKenzie: We'd have to take that question on notice, but I would comment that, for the 2017-18 year, for first responder claims we had an average time of 58.4 days to determine a PTSD claim.

Senator URQUHART: Okay, but I'm interested in the updated figures for 2017-18 and also the fastest approval and then the slowest, so I can actually get my head around the range.

Ms Taylor: Sure.

Senator URQUHART: The report also notes that there's quite a high withdrawal rate in some years—around 10 per cent. This can be because an individual is suffering a psychological injury. Making the application can sometimes exacerbate that injury and delay recovery. How is Comcare working to decrease that withdrawal rate?

Ms Taylor: It's a difficult issue because sometimes we don't know why people withdraw a claim. It may be a positive aspect. Their employer may have intervened early, and so they don't wish to continue with that process. We're trying to make the claims process easier: moving to online forms, making sure the evidence is there, the diagnosis—I go back to the statement from the employer, the statement from the employee and the diagnosis. If we've got those three, we're not reinventing the wheel and sending people off for further examination.

Senator URQUHART: But this is actually people withdrawing a claim, so they have already put it in. It's not a question about putting one in; it's about withdrawing one once they have put it in.

Ms Taylor: A claim can come in and, even before it's determined, people can withdraw that claim for a whole variety of reasons. Sometimes we won't know—

Senator URQUHART: So you don't follow up?

Ms Taylor: why they have withdrawn their claim, no.

Senator URQUHART: Okay. Are you doing anything to try to decrease the withdrawal rate?

Ms Taylor: We're trying to make it easier so that the process isn't the reason why people are withdrawing.

Senator URQUHART: That's the fast tracking you talked about earlier?

Ms Taylor: That's the fast tracking we were talking about. We also have recently, particularly in relation to the AFP, put together a specific team within Comcare to deal with AFP inquiries and claims so that people aren't getting bounced around: if it's early intervention, it's this person or it's somebody else over here. We've centralised that into one team. We've been talking with the AFP about how we can improve services, what they would need in terms of support from us, what the things are that we would suggest that they could be doing and, in particular, improvements around rehabilitation. In discussions in the last few months, I've personally met with the senior AFP leaders on a number of occasions and talked about the issues specifically.

Part of the barrier that was mentioned in previous hearings is getting people to actually put the claim in, and a lot of that goes to the stigma associated with having a mental illness. That can also impede return to work and rehabilitation. There is clearly a stigma with officers returning to work who aren't returning to the duties that they had. They're not carrying their gun; they're clearly identifiable. We've talked with the AFP about some of the assistance that we can provide and how we can put them in touch with the services available. They have a lot of in-house services, but I think the ANAO and the Phoenix report talked about the need for more services and whether they were internal or external. Again, there is the level of trust and confidence that they have with those services.

Senator URQUHART: Can you tell me what medical expenses Comcare covers during the assessment process?

Ms Taylor: This is before a claim?

Senator URQUHART: It is while you're assessing a claim.

Mr McKenzie: We cannot fund medical expenses in the period before a claim is actually accepted. Those services could be provided by the employer under an early intervention program.

Senator URQUHART: So the medical expenses are covered?

Mr McKenzie: It would depend on whether the employer has an early intervention program in place. For example, some employers may have a program that may cover six sessions of psychology or five GP visits or treatments with a specialist.

Senator URQUHART: So that's the employer rather than Comcare.

Mr McKenzie: Yes, that's correct.

Ms Taylor: But, if the claim is accepted, we will—

Senator URQUHART: Yes. I'm interested in the before. What about support for time off work?

Mr McKenzie: Again, Comcare can only make a payment for incapacity benefits for time-off-work benefits once a claim's accepted. In that predetermination phase it may be that the employer has a provision or they may need to take sick leave and be reimbursed if the claim's accepted.

Senator URQUHART: Has Comcare looked at the cost of at least providing some of that during the assessment process?

Ms Taylor: Not specifically.

Senator URQUHART: Why not? Why haven't you looked at that? If employers are doing it, why isn't Comcare looking at doing it?

Ms Taylor: Because currently under the legislation we're not able to do it. We have no ability to pay for anything prior to a claim being accepted. But we've looked at average costs of early intervention, getting the information from some of our employers, and the various types of early intervention that are offered not only in the public sector but also in the licensees. It varies on average: some employers set limits in terms of monetary value, some set limits in number of services offered. If you looked right across the scheme, average early intervention is around $500 to $600, I think. Of course some are higher and some are much lower. We have looked at that, but we don't have the ability to pay anything prior to a claim being accepted. Once a claim's accepted we can reimburse, but our legislation doesn't permit that before a claim's accepted.

Senator URQUHART: You talked a little bit about your fast-track process, and we've heard evidence from pretty much right across the country that the independent medical examiners just aren't trusted by claimants. Claimants say the decisions aren't being made to fairly represent the situations that the claimants are in, and sometimes there's manipulation of evidence. Even the Australian Psychological Society reps weren't prepared to defend the behaviour of some of their members. I'm assuming you do use independent medical examiners at times. How does Comcare ensure that they are providing accurate advice regarding psychological injury claims that is not prejudiced against the claimant?

Mr McKenzie: The reports that we would receive from an independent medical examiner are balanced against the other evidence that exists on the claim: statements from the employer, statements from the employee, reports from treating practitioners. The claims manager will make a determination based on the balance of evidence; however, one of the processes that Comcare are now establishing is reviewing our entire framework for the use of independent medical examiners and looking to make sure that the standards that we have in place are appropriate.

Senator URQUHART: Do you look at the level of expertise and knowledge that that IME may actually have to the type of vocation and work that the people are doing?

Mr McKenzie: Yes, absolutely. When we make a selection to use an independent examiner, we'd be looking to arrange that examination with someone who may have a specialty in PTSD, for example, or depending on what the condition is on the individual claim.

Senator URQUHART: How many of them are around, Mr McKenzie, do you know? Do you know how many IMEs are around with that expertise? We haven't been able to find very many.

Mr McKenzie: There are some challenges in that area with regard to that specialty, and I think that's from both the independent medical examiner's perspective and the treating practitioner's perspective, as was mentioned in some of the other submissions.

Senator URQUHART: Yes, exactly. Recommendation 6 of the ANAO report into the AFP recommended greater record keeping by the AFP, including of Comcare claims. How has Comcare supported the AFP to implement this recommendation?

Ms Taylor: Sorry, Senator, but can you just—

Senator URQUHART: Recommendation 6 says that the AFP should have greater record keeping, including of Comcare claims.

Ms Taylor: One of the issues is about the joining up of AFP systems with Comcare claims, and also the better use of the data that actually they can access from the Comcare system now. We've offered to provide additional training to individuals in the AFP.

Senator URQUHART: Is that like a linking of computers?

Ms Taylor: At the moment they are not linked into their system. I think this was the focus of the ANAO's particular issue about the number of manual systems that the AFP has and not being able to link up some of the lead indicator data, such as absence or absence rates et cetera. The other issue for us is—we, of course, have a data system. We make that available to all of the employers so that they can run their own reports, download information to use in whichever way they want. To make that easier, we provide training to use our system and

provide training on the types of reports. I think it would be fair to say AFP's use of our system has been relatively low in terms of running some of those reports, so we've offered to provide training or, indeed, run some of those reports.

Senator URQUHART: Do you know why it has been low? Why have they not bothered to take it up?

Ms Taylor: I think it's probably a lack of understanding of what the system could provide them. We need to increase that knowledge, to say, 'Actually this report will tell you this, and you can get it from our system.' In some of the conversations that we've been a part of with them, we've talked quite a bit about that.

Senator URQUHART: I would have thought it would be useful for the AFP to pick up that information if they had some commitment to the health and safety of their employees. It would give them more understanding, would it not?

Ms Taylor: It would give them understanding. I'm not suggesting that it's a wilful 'we don't want to know'. What I'm saying is we have observed that lower level use of some of the more sophisticated reporting. We have brought that to their attention and discussed ways in which we can improve their knowledge of what the system can actually do. It's a bit like the 'you don't know what you don't know', so you don't know what the system can provide. We've offered to assist.

Senator URQUHART: I have some more questions, but I might put them on notice.

Senator PATRICK: Ms Taylor, help me out: I presume you base premiums on risk and past history with a client, say the AFP. Would that be correct?

Ms Taylor: We have a method of calculating premiums. We use actuaries to value the premium pool, if you like. We adjust premiums based on the past four years of completed financial year performance, so the premium—there's an overall rate that is varied up or down, depending on the claims performance in terms of cost.

Senator PATRICK: The area I'm trying to explore is how you could potentially use premiums or how premiums may put pressure back on an organisation to change the way it's doing business. While acknowledging the AFP is going through a transformation in relation to this, but, just as a mechanism, has anyone looked at the claims that have been made and then the subsequent improvement and the costs going back to, for example, the AFP, reaction from the AFP? Has anyone looked at those elements?

Ms Taylor: Absolutely. The premiums are always a signal to the premium payer about their performance, and that certainly is the case in terms of Comcare premiums. Where premiums increase, it's very much a price signal that there are issues related to, maybe for very valid reasons, either the severity of claims or the costs. That price signal is sent back through our premiums.

Where there are worsening performances in terms of costs and future predicted liability for employers, worse than what we predicted for the year, there is a penalty imposed if the liability exceeds the prediction. Similarly, if there's an improvement in performance, there's a bonus that the liability has been much less than predicted at the start of the year. There is the price signal of the premium itself, there is the price signal of a penalty if the liability has exceeded the actuarial valuations that you would think, and there is a bonus if performance has improved.

Senator PATRICK: Noting you are a public entity and, indeed, all your clients are public entities, albeit some of them are ACT, I presume that you'd potentially be in a position to be able to provide the committee with perhaps a rolling history of some of these premiums? It would be interesting to see how, for example, the police premium has changed over the last couple of years with the Phoenix report, the Broderick report and other reports playing out—and, indeed, for the ACT. Is that something you're able to provide the committee on notice?

Ms Taylor: Yes; I'll certainly take that on notice. We do the ACT government as a whole. We don't do individual premiums for the individual areas because the ACT government is treated as a whole, so I'm not sure that we could break it down to that level of detail for the ACT government.

Senator PATRICK: But you understand what I'm trying to understand?

Ms Taylor: I understand.

Senator PATRICK: I'm just trying to look at whether that's a mechanism and whether, once again, it's a pressure point we can put on the AFP or a client of yours and to be able to say: 'We note that there's a price signal here. What are you doing about that?' I just think it's a useful tool for us. You mentioned that you've got a special team with the AFP, and that you have had a number of meetings. Is that part of the very active role that Commissioner Colvin is now taking in respect of mental health issues? What's the driver behind it?

Ms Taylor: First of all, the driver is our concern, and our concern over a number of years, about the various reports that have been written—so Phoenix, ANAO, Broderick, our own work in terms of auditing some of their systems—and the price signal of the premium. It's the driver to meet with the senior leaders in the AFP to talk

about how we can assist, because there are clearly issues identified. We monitor the implementation of actions that they've put in place from some of those reports and from our own audits. As part of that we meet regularly with the AFP. I've also raised this a level by meeting personally with them on a number of occasions in recent times.

Senator PATRICK: Are you in a position to be able to give an indication to the committee, noting that things like Broderick and Phoenix go back a year or two years, as to whether or not there is a decrease in premiums at this point in time?

Ms Taylor: There hasn't been a decrease in premiums at this point in time, but I will—

Senator PATRICK: Has there been an increase then?

Ms Taylor: Sorry, Senator, I didn't mean to be completely obtuse there.

Senator PATRICK: There are three options: it stayed the same, it didn't reduce or it did.

Ms Taylor: Yes, premiums have increased. I will say that implementing change such as that recommended by Phoenix, ANAO, Broderick, our audits et cetera—for the impact of that change to flow through to something like a premium can take some time. Although we've seen an increase in premiums, that doesn't necessarily mean that AFP have just done nothing. In fact, they have done an enormous amount, and Commissioner Colvin's commitment through the plan released in May this year is clearly evident, but they will take some time to flow through the system. And when you're particularly talking about cultural change in an organisation, we know that that can take a number of years.

Senator PATRICK: I know the Broderick review is public, as are the Phoenix review and the ANAO report. Are your audits public?

Ms Taylor: No, they're not.

Senator PATRICK: Is it possible for you to table your audits in respect of the AFP?

Ms Taylor: I'll take that on notice.

Senator PATRICK: Thank you.

ACTING CHAIR: Thank you very much for your time.

AHERN, Mr Colin, Executive Manager, Workers Compensation, CGU Insurance

CATCHPOLE, Mr Noel, Manager, Western Region, Workers Compensation, Allianz Australia Insurance Ltd

KOZAK, Mrs Maria, Senior Consultant, Workers Compensation, Jardine Lloyd Thompson Pty Limited

NEAL, Mrs Sarsha, Divisional Manager, Jardine Lloyd Thompson Pty Limited

SCOFIELD, Mr Nicholas, Chief Corporate Affairs Officer, Allianz Australia Insurance Ltd

Evidence was taken via teleconference—

[11:09]

ACTING CHAIR: Welcome. I understand that information on parliamentary privilege and the protection of witnesses and evidence has been provided to you. Thank you all very much for appearing via teleconference today. I invite you to make opening statements. Does anyone want to put their hand up to go first?

Mr Ahern: Thank you for your invitation to appear before the committee and for the opportunity to make an opening statement. As we know, mental health claims present a significant challenge to personal injury schemes across the country, and our experience at CGU is no different. While some claims can have the same diagnosis, each claim is materially different to every other and therefore requires a personal approach to understanding the complexity of the mental health condition to develop strategies to support and treat with the goal of achieving a successful return to work and health.

In early 2017, CGU decided to re-evaluate our approach to how we handle claims in our portfolio with mental health challenges as either a primary or a secondary injury. In what ultimately became a five-phased approach to re-engineering our approach, we engaged psychiatric consultants to review a tranche of high-risk claims and evaluate our claims management handling capability. High risk in this instance is defined as claims where there had been an attempted suicide, suicidal ideation, self-harm or threatened self-harm.

The outcomes of the review were recommendations to improve our management of mental health claims. After the claim was reviewed, the second phase was to conduct sessions with our staff, designed to educate and help them better understand mental health, triggers for mental health and barriers to return to health and/or return to work. The third phase was the introduction of biopsychosocial screening for all new claims so that we could better identify claims which were high, medium and low risk, and assign the appropriate care based on the complexity of the claim.

Phase 4 was the introduction of a pilot program with a clinical psychologist, aimed at disrupting the cycle of certification for mental health claims, focusing on coaching and guidance for the treating health practitioner to better support the needs of injured workers with mental health challenges. The intent was to also avoid the use of independent medical examinations by gathering information directly from the worker, their employer and their treating health practitioner, because the process of attending an IME, for a person with mental health issues, often exacerbated the mental health condition.

This specialist approach supported the treating health practitioner, in most cases the family GP, to help them understand the condition, how best to treat and how best to support a return to work where appropriate. Where a change in certification was identified, in most cases an occupational rehabilitation consultant was engaged to develop a return-to-work plan in conjunction with the injured worker and their GP.

The last phase of our program was the employment of a psychiatric nurse to our team of return-to-work specialists. High-risk mental health claims identified through the biopsychosocial screening would be referred to the psychiatric nurse as a priority to determine the appropriate care for the claim right from the outset. Part of the responsibilities of the psychiatric nurse was to support our claims consultants in managing mental health claims in their care and determine appropriate support and treatment pathways to aid a return-to-work outcome. Specifically for first responders, in addition to the initiatives that I have outlined, we are now developing an approach utilising exercise physiologists. Exercise physiology can play a significant role in managing mental health pre claim, when a claim occurs and post claim after a person has returned to work.

Lastly, we are soon to pilot a program that focuses on rebuilding resilience and self-esteem for those who become disempowered whilst dealing with mental health issues. Using neuroscience and emotional intelligence as its basis, the program aims at empowering people to take steps to take back control and recommence making decisions about their future.

ACTING CHAIR: Thank you very much. Mrs Neal or Mrs Kozak, do either of you wish to make any opening remarks?

Mrs Kozak: Yes. Thank you for the opportunity to speak to you about the important issue of mental health. JLT, or Jardine Lloyd Thompson, as insurance brokers for St John Ambulance Western Australia, has assisted St John Ambulance in regard to the management of their mental health claims in the workers compensation space and has been integral to the development of their Motivated Minds program, which brings about the determining of workers compensation claims in a timely manner to ensure that their workers receive the appropriate treatment.

ACTING CHAIR: Great. Mrs Neal, do you have anything to add?

Mrs Neal: No—just in line with Maria's comments.

ACTING CHAIR: Great, thank you. Mr Scofield?

Mr Scofield: We thank the committee for the invitation and opportunity to appear. You would be aware that Allianz didn't make a submission to the inquiry. But we became aware, through our friends at JLT, that the previous witnesses or submissions had referred specifically to the Motivated Minds program that Allianz and JLT jointly manage with St John Ambulance Western Australia. We are pleased that the committee has taken an interest in that particular program. My colleague Mr Catchpole, who is from our Western Australian business, looks after that and can answer most of the detailed questions in relation to it.

ACTING CHAIR: Great. Mr Catchpole, do you wish to make any opening remarks?

Mr Catchpole: No, thank you very much.

ACTING CHAIR: Could whoever is best placed to do so talk us briefly through the Motivated Minds program—what it looks like before the first responders are involved and how they interact with it.

Mrs Kozak: The Motivated Minds program was developed in approximately 2015 in conjunction with our then workers compensation insurer CGU Insurance and St John Ambulance WA and JLT. The program was designed on the back of what can only be described as an increase in the number of mental health claims coming through to workers compensation from St John Ambulance. What was noted initially was that misdiagnoses were being made by some of the practitioners in regard to mental health issues. Accordingly, when the worker entered into the system, they were receiving the wrong treatment and so forth because of that incorrect diagnosis. Because the workers compensation system in WA can be quite cumbersome when it comes to mental health claims, Motivated Minds was designed to establish a process by which these claims were dealt with in a more timely manner so that injured workers were receiving a correct diagnosis and could then receive the appropriate treatment in a very timely manner. So what we did was engage with the relevant stakeholders in the Western Australian market in terms of psychologists and psychiatrists. We were able to refer St John employees who had lodged a claim, within a 24-, 48- or 72-hour period once that claim was lodged, to the psychiatrist for review so that a correct diagnosis of their condition could be made. Once that diagnosis was known, the claim could be very quickly accepted by the insurer and appropriate treatment could be immediately commenced.

That was the basis of how the program started. From there, the program developed further. We would employ the services of a vocational rehabilitation specialist to assist that injured worker in facilitating their treatment and ensuring that they were having the appropriate treatment at the appropriate interval, and also to discuss very generically what a return to work at St John Ambulance may look like.

We then developed phase 2 of the program. That looked at return to work. What we found was that, when workers would initially return to St John Ambulance, they would go back in and do some duties and they might struggle with that, and then they would be certified as incapacitated for work again. So what we then did was change the focus away from a return to work. In the early months after a diagnosis of a mental health issue, we focused on a return to functions of daily living. We focused on things like speaking to the worker about what interested them—for example, whether they had an interest in exercise physiology or some other type of leisure pursuits that they felt might assist them in their recovery. And that is what we then began focusing on. With the then insurer CGU, and more recently with Allianz, we have had support to pay for those programs so that those workers can engage in those programs. With that, we have seen more discussions in return to work focusing on being reintegrated back into St John in a very gentle manner and when the worker is ready to do so.

Senator PATRICK: I am interested in the link between the increasing number of claims, insurance premiums and conversations or interactions you might have with the insured to put pressure on them to do more preventive work or earlier detection.

Mrs Kozak: In regard to interaction with the worker lodging the claim—

Senator PATRICK: Sorry, I mean more particularly with the insured organisation—WA Ambulance for example. They are the ones paying a premium. One presumes that, if you get more claims and later detection

requires costlier remediation, there is a link between the organisation's performance in relation to mental health and the premium.

Mr Catchpole: I think that's the basis on which Motivated Minds came into effect—with a view to coming up with alternatives to reduce time lost, to reduce claims and to get that premium reduction. It is a complex area because, at the same time, we are looking at ways to manage PTSD claims in a way that is going to get a great outcome, or a recovery, from a worker's point of view. I'm hoping that the way we are managing those claims also helps with the stigma that is sometimes associated with lodging claims. The Motivated Minds program is really the key that we are trying to develop to achieve so many different outcomes, including cost reduction.

Senator PATRICK: Is there a case study of some entity that has really taken the problem by the horns and done something about it and where there is a resultant reduction in premiums? You could then use that as an education tool for financial managers inside some of these organisations. Or is that the plan with the current program—to measure a change and then promote similar approaches in other organisations?

Mr Catchpole: Yes, that's exactly what we're trying to do. As Maria said, the Motivated Minds program has been tailored; we have gone into phase 2. We were hoping to see some fairly impressive results as a result of that, but it is probably just a fraction early to jump for joy in that regard. Obviously, there are other issues as well around return to work. That can be difficult. We try to provide meaningful return-to-work options. But bear in mind that, with the kind of work that first responders do, it can sometimes be hard for them to get the same community self-worth out of a role that is not the same as being a paramedic or a first responder.

Mr Ahern: Senator Patrick, I want to go to your point regarding the connection between the claim cost and the premium. Mental health claims here in Victoria a few years ago represented 10 per cent of all claim numbers, and now they are at about 14 per cent. Six months post injury, physical claim return-to-work rates are at about 83 per cent, but for mental injury claims they are at 53 per cent. So, whilst the claim numbers are lower than physical claims, the return-to-work outcome for mental health has a much longer duration. That transfers into claims costs and, ultimately, premiums.

The pilot program that we did, which I spoke about in my opening statement, uses a clinical psychologist to disrupt the cycle of certification by focusing on the treating health practitioner. It also obviates the necessity to get an independent medical examination—which is the traditional pathway—because sending a person with mental health challenges to an examination often has a detrimental effect on their condition. What we saw through our pilot program that we ran last year was that we were able to get a change in certification for 40 per cent of the claims where there was a full return to work. And that return to work came with conditions, which is why, in over 90 per cent of cases, we engaged an occupational rehabilitation consultant to assist with return to work. We also saw a change in certification on 82 per cent of claims. So if we are getting people back to work, even though some of it might be in a part-time capacity, it will actually transfer from the cost of mental health claims and reduce premiums. Over the last three years the claims of the Country Fire Authority here in Victoria, who we represent, have reduced. They had eight claims in 2016, five claims in 2017 and only three claims in 2018. The claims are categorised into two areas. There is post-traumatic stress as part of the condition. There are also the people who work in the office, from the support and operations area, who are taking the calls from people who are in distress.

Senator PATRICK: So who is driving the effort—the insurance companies or the insured? Where is the drive coming from? A number of organisations, particularly ambulance drivers and paramedics, are telling us that part of the problem is organisations cutting costs, putting stress on workers and so forth, hence my interest in trying to get a financial motive on the other side of the coin. Who's driving it? Is it the insurers or the insured?

Mr Ahern: I think it's a combination of both. We work with our employers, in terms of their occupational health and safety, and we meet with large employers, like the Country Fire Authority, on a monthly and quarterly basis. Our executive review programs look at the actual claims costs and what's causing the claim, and that allows us to focus on what the drivers of claims costs are and what the things they need to do at the workplace are. From an employer perspective—so the Country Fire Authority—they pay their premium based on their claims performance and their claims history, and therefore that's a financial motivator. If their claims history is driving their premium performance up, it's a financial motivator. But what we're finding is that there's been a real shift with employers, probably over the last 18 months, where people are really focusing on the culture of workplaces and ensuring that the right culture drives the right behaviours. Therefore, we're seeing that reduce. But, at the same time, there's a lot more awareness around mental health conditions, which is actually increasing the number of claims despite the efforts to improve the culture of workplaces.

Senator PATRICK: This might be a hard question to answer, because of all the different, varying circumstances, but I'm trying to get a feel for the adjustment in premiums for an organisation like an ambulance

service or a fire service, from year to year, as a result of claim activity. Does it vary by a hundred thousand or a million? What's the order of magnitude of variation? This is just to get a sense of how much of a motivator it may be for the CFOs of these organisations.

Mr Catchpole: Again, it is a difficult question, because there are so many variables. When you're determining premiums you're determining what the likely cost of a claim is going to be, and that can change. Hopefully programs such as Motivated Minds will mean that the cost of claims will go down. It's hard to give you a specific view. I'm not trying to dodge the question, but it's very hard to provide a figure. It could be tens of thousands; it could be hundreds of thousands. It could be, if their claims experience improves, a lesser rate than the previous year.

Senator PATRICK: But not millions?

Mr Catchpole: No.

Senator PATRICK: You're talking hundreds of thousands, possibly.

Mr Ahern: I agree exactly with what Noel had to say in that there are too many variables to make a specific comment; however, suffice it to say that there are financial motivators within the premium formula in Victoria for people to improve their claims performance, year on year, and if they don't then they will have a financial impact for not one year but probably a three- to five-year window. What we're seeing is a real change in the way employers think about work health and safety, specifically in regard to mental health conditions, because they understand the connection between the culture in an organisation, the claims cost and the financial motivators you're talking about.

Senator URQUHART: I might go to Allianz first. My first question was to get you to explain your approach and policies for managing workers compensation claims for mental health and psychological injuries for first responders. I think, Mr Ahern, you covered off fairly well in your opening statement the process that CGU have developed. I'm interested in Allianz's approach.

Mr Catchpole: Maria from JLT can probably assist here. If we're looking at Allianz's approach specifically to PTSD claims in Western Australia, we're looking at ways to speed up the process, and we've done that through targeting diagnosis and treatment as against liability decisions. We've put in place a program where our acceptance rate around St John overall is about 94 per cent. We've tried to alleviate some of the problems that can be experienced with mental health and in getting access to workers and them having to relive stories and the like. By going through and getting the treatment first, we have kind of shortcut the problem of determining liability. That's one of the key things, I think: we've seriously reduced the amount of time to get a determination of liability and focused on treatment and diagnosis. Did you want to add to that, Maria?

Senator URQUHART: Sorry, can I jump in there. In relation to that, you focus on treatment rather than determining whether you're liable. In that first process before liability is determined, who pays for the treatment?

Mr Catchpole: We will fund Motivating Minds, the specialist treatment providers, on a without-prejudice basis. That's always funded by us up-front. As far as the costs associated with weekly wages go, St John have a program in place where they'll pick that up and, obviously, when the claim gets accepted we reimburse them.

Senator URQUHART: If the claim isn't accepted?

Mr Catchpole: Are you talking about a claim that's declined?

Senator URQUHART: Yes.

Mr Catchpole: Then it's a process whereby the worker would have the option to go through and lodge an application at WorkCover. Liability, if it's in dispute, gets determined at a later date. St John, I'm assuming, would have the facilities to make payments in respect of annual leave or sick leave entitlements, and if liability were approved down the track then that would be recredited.

Senator URQUHART: That's fine. I won't labour on that anymore. What is the relationship between JLT—which I understand is the broker—and Allianz, with respect to St John Ambulance in WA?

Mr Catchpole: JLT is the broker for St John Ambulance, and they provide two things: obviously insurance placement—actually, I should let Maria answer this one—and also a claims consultant service. As Maria said, the program was with CGU previously and came to us over the last couple of years. They've been engaged to look at ways to improve claims handling internally with St John. Hence they developed, in conjunction with them, a program to assist them in that regard and also to assist workers.

Senator URQUHART: Just so that I can understand that, Allianz is the insurer—

Mr Catchpole: Correct.

Senator URQUHART: A worker has an injury. They then fill out a claim form, and that goes to Allianz?

Mr Catchpole: Yes, it would normally go to St Johns first, and then it would come to us.

Senator URQUHART: Do JLT have any role in that?

Mr Catchpole: Not in determining liability, no. Certainly not from an insurer perspective—if they have, I would suggest they would be involved with the employer.

Senator URQUHART: But in terms of determining the outcome of a claim, is it purely Allianz and the employer?

Mr Catchpole: Yes. Maria, do you want to jump in?

Mrs Kozak: What Noel was saying is correct. When a worker lodges a claim with St John Ambulance, the claim is sent through from St John to Allianz, and then the process commences by which liability is determined. JLT has no involvement in that decision as to whether liability is accepted or denied. However, post the acceptance of the claim, we do assist in claims handling, in terms of ensuring that St John and Allianz are providing that worker with what they need to ensure that (1) they receive the appropriate treatment, and (2) things are done to facilitate a return to work when appropriate.

Senator URQUHART: So JLT has a role once the determination has been made to accept liability?

Mrs Kozak: That's correct.

Senator URQUHART: And that's in relation to treatment et cetera?

Mrs Kozak: Yes.

Senator URQUHART: Is it fair to say that the injured worker then effectively has three bodies to go through—that is, the employer, Allianz and JLT?

Mrs Kozak: No. We don't have any direct involvement with the injured worker. The communication with the injured worker is done either via St John Ambulance or—if there are matters relating to the claim—by Allianz, so JLT has no direct communication with the injured worker.

Senator URQUHART: So effectively it's JLT's role to determine if a treatment is reasonable and acceptable, and then that's fed back to Allianz, who then feeds that to either the employer or the worker. Is that correct?

Mrs Kozak: No, not to determine whether that treatment is appropriate. That's left to the medical evidence. What we do is work together—St John Ambulance, Allianz Australia Insurance and JLT—to ensure that the worker is receiving what they need to. It may be, based on my years of experience in the workers compensation system, that I might look at a claim that has come across from St John and I might make suggestions as to what other treatments, what other things, may assist that injured worker in returning to work. For example, perhaps the concept of attending yoga classes or poetry classes hasn't been explored, so I would suggest it to St John and/or Allianz Insurance and say, 'Is this something that the injured worker would like to consider?' That then gets put to the injured worker via Allianz and/or St John, and then the injured worker can make a decision. We don't advise St John or Allianz that the treatment is appropriate or anything like that. We simply support St John Ambulance and Allianz in their management of those claims.

Senator URQUHART: Over the course of this inquiry, and in my previous life, I've heard on numerous occasions about the combative nature of the traditional workers compensation system and how that may contribute to further psychological injury. Can you talk me through your company's experience with this and what steps, if any, you're taking to ensure that people are not further traumatised through the workers compensation process.

Mrs Kozak: That's exactly why Motivating Minds was designed to assist. You were talking earlier with respect to claims cost. This program is designed to manage both of those things, claims cost and the injured worker, at the same time. That's exactly why this program was designed, so that we don't have this combative process anymore with regard to mental health claims and so that a worker can know quite quickly, easily and without any extra stress how the process is going to work, what is going to happen—as Noel said earlier with regard to the St John Ambulance statistics—that their claim is going to be accepted and that it is quite a simple process.

Historically in Western Australia, mental health claims have been quite combative. They have generally taken a considerable time for insurers to determine liability, and that has added extra stress to injured workers. But with this program that we've devised with St John Ambulance and the incumbent insurers it is to ensure that these claims are processed quite quickly, and we're now able to do that with inside of 14 days maximum.

Mr Catchpole: I will just jump in and confirm or reiterate what Maria has said. We've also got a system in Western Australia that, I think, provides very good legislation. I think it's administered very well by WorkCover WA. The adversarial nature of claims going back a number of years might have been there. I think it's less and less, to be perfectly honest. WorkCover are also looking at making some amendments to their legislation early next year. I think they'll be bringing in provisional payments and I think that will, again, take another step towards making it less adversarial.

Senator URQUHART: I'm conscious of time—

Mr Ahern: I know you were focusing on Allianz and JLT, but I think part of the important point that we raised in the way in which we're looking at claims at CGU was the biopsychosocial screening which happens parallel to the determination of liability. In Victoria, you have 28 days to determine liability, but we're acting on claims regardless of whether they're accepted, rejected or pended so that we can actually start work on those claims before they are 10 days old. Most liability decisions are made within the first seven days, but where a claim is pended because it needs a bit more information or investigation we still work on those claims, working towards an outcome rather than just leaving them until a liability decision is determined, because that's the best pathway to get an outcome.

Senator URQUHART: I'm conscious of time and I've got a lot of questions, so I'm going to try to get through them as quickly as I can. If you could maybe compact your answers as much as you can, that would be great. I will just ask the different companies: do you use independent medical examiners to make assessments?

Mrs Kozak: Yes.

Senator URQUHART: Allianz?

Mr Catchpole: Yes.

Senator URQUHART: And CGU?

Mr Ahern: As I outlined, with our mental health claims now we're actually using a clinical psychiatry program to obviate the necessity to go to IMEs, because we actually see them as being adversarial in terms of trying to help the anxiety of an injured worker.

Senator URQUHART: Just going back to the other two, how do you ensure that there are no incentives for IMEs to delay or reject a claim?

Mr Catchpole: I think we're dealing with two separate things here. If we're talking about Motivated Minds, I think Maria can answer that. But obviously the priority is to get people in, which we do extremely quickly. The priority is treatment and diagnosis, as against liability. That's the main issue. For IMEs in general, I would hope that all IMEs that we use are not biased and provide valued opinions in respect of the same things for treatment, return to work and liability. I'm not sure exactly; I haven't come across too many situations where we've actually had complaints about bias in respect of IME assessments. I've been around a long time; historically there are obviously specialists that, from a plaintiff lawyer's perspective, may provide a report that slants a certain way, and similarly with insurers. As far as Allianz goes in Western Australia—and, I'm assuming, across the country—biased or one-sided opinions are not something that we condone, and they certainly won't be condoned by WorkCover WA, if you have a dispute.

Senator URQUHART: Can you take us through how many claims for psychological injury have been accepted and how many have been rejected over the last five years by each of your companies across the first-responder organisations that you cover? I'm conscious that you may need to take that on notice. I'd be interested to know how many of those have been settled.

Mr Catchpole: I can give you a couple of years in respect of St John Ambulance. There have been 18 PTSD claims admitted by St John since we've been on risk, 14 of which were accepted, two of which weren't declined but were picked up by the previous insurer—in this case CGU, who did so without question, which is fantastic—and there are two claims that were settled on the basis of, I think, a contribution from both CGU and Allianz, on the basis that we believed the claim was as a result of an exclusion under the act; in other words there was a disciplinary action which prompted the condition. Those claims were settled prior to a hearing at WorkCover.

Mr Ahern: There are 333 claims that have been lodged over the five-year period in question. There are 28 mental health claims. Six of the 28 mental health claims were rejected. All claims were rejected on the basis of reasonable management action.

Senator URQUHART: We had a hearing in Fremantle where the Western Australian Department of Fire and Emergency Services explained that their insurer, RiskCover, has, since, I think, 2010, accepted liability for all PTSD claims lodged by first responder workers and funded preventive therapies on a without-prejudice basis

before determining liability. Since then, the Tasmanian government has announced it'll change its workers compensation system to a presumptive approach for PTSD. Can you comment on whether any of your companies have considered such an approach? From Allianz in particular, can I ask you what engagement you've had with the Tasmanian government about the new approach? I understand that they've issued orders such that all PTSD claims will be managed on a presumptive basis until the law is changed, and I think that will be next year.

Mr Scofield: You're correct in your understanding of what has occurred. Since the announcement has been made, the WorkCover authority has directed insurers to, effectively, handle claims as if the presumptive law were in place, and so that's being done as we speak.

Senator URQUHART: Are you considering that in other areas?

Mr Scofield: I think it's fair to say that the Motivated Minds program is, essentially, bringing about the same outcome as presumptive legislation. As Mr Catchpole mentioned, medical costs are paid on a without-prejudice basis prior to liability being determined. With the Western Australian government looking at legislation around preliminary payments, those two things combined would effectively achieve the same result as presumptive legislation would.

Senator URQUHART: CGU?

Mr Ahern: In Victoria, there is a draft bill in parliament at the moment in regard to the presumptive model and legislation specifically for emergency services workers, but there is an election about to happen, so it is probably not going to go to parliament until the new year. With the approach that we've trialled as a pilot here in Victoria, it sort of replicates the presumptive model. We're in discussions with other jurisdictions about rolling this out so that we actually get moving on a claim earlier than the last claim.

Senator URQUHART: I know that all three first-responder organisations covered by your insurance products engage a large number of volunteers as well as key paid personnel. Can you briefly let me know what improvements you think are needed to better support volunteers and rural professionals in particular.

Mr Ahern: The Country Fire Authority has a scheme called volcomp. In our meetings with the Country Fire Authority, we talk to them, saying that the applicability for the initiatives that we're doing with the Country Fire Authority and their staff apply for volcomp. They're used as a collective basis for discussion when we're meeting with CFA.

Senator URQUHART: I know this is important in WA, particularly where you've got rural professionals who are predominantly working on their own, sometimes with community volunteers.

Mrs Neal: For St John's specifically, we do actually have what we call a personal accident policy for the volunteers that are working. Whilst they don't fall under the Workers Compensation Act, they do have access to a personal accident policy whereby there are medical costs associated that are covered. If there is need for psychiatric treatment or any support required, the policy does pick up a component of that also.

Senator URQUHART: So it covers their medical. But, if they were injured and weren't able to partake in their normal employment, what would happen?

Mrs Neal: There is a component for weekly benefits as well that can be taken out.

Senator URQUHART: Okay. Is there a limit on that or a time frame?

Mrs Neal: Off the top of my head, I think the standard personal accident policy in general is about 104 weeks. There might be an excess of seven days.

Senator URQUHART: Is there a process that you would undertake similar to a workers compensation acceptance of liability?

Mrs Neal: Because of the nature of it, particularly for St Johns, we would get them to work with the workers compensation team internally as well so that they're getting the same sort of support and guidance. Whilst it's not a workers compensation claim, we can treat it in the same manner to provide the injured worker with some support.

Senator URQUHART: Mr Scofield, I wanted to raise an issue with you that just came to light yesterday. It was a media report by Emily McPherson of Channel Nine news. It was titled 'Firefighter left with brain injury has insurance claim rejected'. I understand that Allianz used privacy reasons to refuse to give specific details to the journalist on that particular matter. You're obviously aware of that media report?

Mr Scofield: I am, yes.

Senator URQUHART: I'll ask you some general questions. Can you tell me what the virtue for Allianz is in changing a workers compensation claim from accepted to rejected partway through treatment for a workplace injury?

Mr Scofield: That, in fact, is not what has occurred. I know particularly that the headline in relation to that story gave quite a false impression. The claim is still ongoing. The claim has not been rejected.

Senator URQUHART: Okay. If it hasn't been rejected, is there anything that you could provide to the committee, and particularly to the wider Australian population—there are a lot of people who are interested in this inquiry—about the treatment of a firefighter whose workers compensation claim was changed from accepted to rejected, as I understand, for ongoing treatment for pain management? I understand that he suffered a brain injury while fighting a wildfire in Tasmania's Southwest National Park in February 2016. I'm interested in why, all of a sudden, the payments stopped. What provides Allianz with the justification to stop workers' entitlements to get medical treatment?

Mr Scofield: To be honest, out of respect for the worker's privacy, I don't want to go into a lot of detail in relation to the particular claim. At various times during the process of a claim, from the initial injury through to the recovery stages and to, hopefully, a full recovery, different sorts of treatment will be deemed to be appropriate, needed and effective. That will change through the life of the claim. It's not uncommon for treatments to evolve as recovery proceeds. There would be changes made to those treatments. Obviously, our considerations around those are based on independent medical advice. They're not done, if you like, without that third-party professional expertise being brought to bear.

Senator URQUHART: So you've used an IME?

Mr Scofield: We've used a medical specialist to provide advice on the effectiveness of the treatment that has been in place for some time and whether there are alternatives or whether particular types of treatments are achieving desired outcomes.

Senator URQUHART: When you say 'desired outcomes', Mr Scofield, are you talking about desired outcomes for Allianz or desired outcomes for the worker?

Mr Scofield: I mean for the worker. I'm talking about the effectiveness of the treatment itself.

Senator URQUHART: Right. But for a worker, in most cases, to obtain medical treatment for a work injury, they are supported by their treating GP and possibly other specialists. Then the insurer has the opportunity to wheel in an IME, which then provides an alternative position, and that treatment is then stopped on the basis of the IME's position. Is that what occurred here?

Mr Scofield: No. We have had specialist medical advice throughout the life of the claim, so it's not a question of someone coming in at some sort of midpoint stage and a change in the decision being made. The treatment and the recovery and the effectiveness of the various treatments that are being received are continually monitored throughout the life of the claim, and if it gets to a point where the advice we receive is that a particular sort of treatment either is no longer appropriate or has been trialled for a significant period of time but is not proving effective then we will look for alternatives.

Senator URQUHART: You'd be aware that there has been a GoFundMe page launched to support the cost of this firefighter's treatment. Has Allianz made a donation to the GoFundMe appeal?

Mr Scofield: We haven't, no.

Senator URQUHART: One of the things that worry me, when we talk about the state of workers compensation insurance in this country, is where an individual who has sustained an injury at work and then had the treatment cut off then has to rely on a community fundraising appeal. My question to you is: is legislative reform needed to provide greater clarity for insurers, workers and the general community around these sorts of issues?

Mr Scofield: I think it's true that most injury compensation schemes, whether they're in the workplace environment or the motor vehicle environment—or the NDIS for that matter—are essentially based on an assessment of what is deemed reasonable and necessary, in terms of the provision of medical treatments, supports and any other services that might assist the person in recovering their health and their employment situation and getting back to work. I think it's also fair to say that medical professionals can at times legitimately disagree on the nature of the efficacy of some particular treatments. So I'm not sure whether it's so much an issue of clarity; I think it's more that, for the vast majority of claims and circumstances, issues don't arise where differences of view emerge as to what the best form of treatment at a particular point in time is, but sometimes they do.

Senator URQUHART: Do claimants have the opportunity to seek their own specialist medical advice to support their workers compensation claim?

Mr Scofield: They certainly do. They also have access to various no-cost tribunals that they can go to to get independent review of an insurer's decision.

Senator URQUHART: What about in terms of a review part-way through treatment? Does a claimant have an opportunity to seek their own specialist medical advice then?

Mr Scofield: They will be under their own medical advice and care throughout the life of their injury.

Senator URQUHART: No, sorry—

Mr Scofield: If you're talking about in relation to a decision that's made in the course of a claim, they certainly have the right to have that decision independently reviewed through the scheme tribunal and to present any medical evidence that they have to support their case.

Senator URQUHART: I probably should rephrase that. I understand they have a right to get their own medical advice, but what weight does that hold for an insurer such as you?

Mr Scofield: The reason that we use independent medical advisers is that, in specialised areas of medicine, we don't have the internal capability to assess those treatments that have been proposed or recommended. The medical professional that we engage to review a recommended treatment or whatever will certainly take into account the views and the opinions of their colleague in the medical profession.

ACTING CHAIR: We've got a request from the media to film. I assume there are no objections to that. While I've got the floor: Mr Scofield, if there is a difference of opinion between an independent examiner and a GP, would an insurance company then go to a third party? How would you handle that situation?

Mr Catchpole: Can I just jump in? It's not a St John claim, but it's probably a good example of the question you just asked. We have a claim where a treating specialist recommended surgery on a worker at two levels in the spine. We sought specialist opinion, mainly on the basis that doing the two surgeries at once seemed a concern. The specialist came back and said he believed surgery was required but he would never do both at the one time, for recovery reasons. So we went to a third specialist, in Queensland, who came back and agreed with our specialist. It wasn't an issue on costs, because it would have been cheaper to perform the surgery on both levels at the one time. It was about worker safety, I guess, and his eventual recovery. So there are times that we go to a third specialist and there are times that we're looking after the worker's interests in front of costs.

ACTING CHAIR: Certainly. Mr Scofield, do you have anything to add with regard to just the general process if there is a disagreement between the treating physician, or the person's own GP, and an independent medical examiner? Do you always then go to a third party? How do you resolve that difference of opinion?

Mr Scofield: It would in some cases involve going to a third opinion to try and resolve any misalignment in the views. The other main point is that, if it goes through into a review process, that's likely to be a natural consequence of that review process in any case.

Senator URQUHART: I want to go back to the point I was asking about earlier, and that is: if a worker goes to their own specialist, what weight does that have compared to individual specialists in relation to the IME?

Mr Scofield, you were questioning the value of a treatment for an individual, and obviously you've got advice that says you don't believe this treatment is the best. I understand that a worker has the opportunity to go off to their own specialist, but what weight does an insurance company put on that compared to their own IME advice?

Mr Scofield: I don't think it's really a question of the weight of one over the other.

Senator URQUHART: It would be, if they were quite different results. If the IME said something and the treating specialist said something different, you'd have to put a weighting on it, wouldn't you?

Mr Scofield: You could say that, but what I was going to say was: we are obliged as claims managers, under the legislation, to also consider what's reasonable and necessary—the phrase I referred to before. So, the considerations that we may have in relation to a claim, a particular treatment or whatever, may differ from what a medical specialist might be considering. Sometimes it's of that nature. It's not really us saying that that recommended treatment would be bad or not produce any result at all. But, in the overall management of the claim, under the legislation in which we operate, we have to consider whether it's reasonable and necessary. That's where we seek specialist advice, particularly around the question of effectiveness because, if a treatment is largely ineffective, that's something we need to take into account.

Senator URQUHART: The legislation that you refer to is the minimum that you're required to operate under; it's not the maximum. You can actually provide better. So, in terms of 'reasonable and necessary', how do you make that judgement?

Mr Scofield: Obviously, every case is different. I would say, though, that I don't think it's true to say that it's a minimum. It is, essentially, a regulatory requirement we have as the claims manager. It's not really saying that this compensation or treatment, or whatever it might be, should be reasonable and necessary, but you're free to go as far above that as you feel—because to do so would potentially be providing something that was unreasonable or unnecessary.

Senator URQUHART: I've just got a couple more questions, Mr Scofield—and I thank the chair for his generosity in giving me a little extra time. I would question how, for a worker who's injured and receiving pain management treatment, it is not deemed to be reasonable and necessary, particularly if that is helping the worker to get back to work. What alternatives are on offer?

Mr Scofield: As I say, I don't think it's appropriate to talk too much in detail about a specific claim, but I don't think what we're saying here is that the alternatives are pain management treatment or no pain management treatment. The potential disagreement here is purely around the effectiveness and the efficacy of particular types of pain management treatment.

Senator URQUHART: So other things are on offer—is that what you're saying?

Mr Scofield: There are a plethora of different treatments, medications and various things that can be used for the management of pain. It's available for medical professionals to have different views and that is essentially why these teams have a tribunal or some sort of independent review process, whereby if the two parties can't resolve a difference in view, then it can be done independently.

Senator URQUHART: So we go back to that combative nature of workers compensation again, don't we? That's still the process, isn't it?

Mr Scofield: At any one time across Australia there will probably be hundreds of thousands of active workers compensation claims—certainly tens of thousands of them—and, in the vast majority of those cases, there is no combativeness or problem between the insurer and the injured person. Any sort of injury, whether it's achieved in the workplace or not, is going to cause stress and anxiety and be a very emotional time in the life of an individual. On very, very few occasions out of whatever that number is—those tens of thousands—of actively managed workers compensation claims, disagreements arise and the scheme has the processes to bring about the resolution of those.

Senator URQUHART: I understand that, but I guess my concern is that we clearly have a worker who was injured in the course of his duty as a first responder, fighting a fire and was hit in the head, and, in the interim, while waiting for the decision or a decision of the tribunal, which can sometimes take months, the claimant is then responsible for paying for the treatment that enables him to return to work. It doesn't make a lot of sense to me.

Mr Ahern: Senator, I can't speak to the claim that you are talking about with regard to Allianz, but will give a couple of 'for instances'. We rejected an application for medicinal cannabis for a person with a mental health condition, because we could find no research, nor could the treating doctor find any research, that demonstrated that medicinal cannabis would actually be helpful in addressing the mental health condition. We've also rejected claims on a couple of occasions for two weeks of health retreats because, again, we don't see that the specialist help that they require would be received at a health retreat. So it just depends on the nature of the request. We'll look at the case—and we have medical advisers that work on our teams, and we've got a clinical psychiatrist at CGU—but it just depends on the nature of the request, because you do get some requests where we don't consider that it would be helpful to the recovery of the patient.

ACTING CHAIR: Can I just jump in and ask a follow-up question there. I am not making a comment on any particular case. I have no idea of the details of this particular case or any other. Do the insurance companies take a view on, say, long-term opioid use to treat pain? That has obviously been in the media a bit and is something that can be seen as counterproductive, particularly over the long term. Do the insurance companies get involved at all in that sort of question, or is that purely something for the medical profession?

Mr Ahern: It's something that we're looking at at the moment. We haven't made a decision on it; we're still doing our research into it. At this point, we aren't approving opioid use, but we are looking into the value that it might be able to deliver to people, particularly from a physical injury claim perspective.

ACTING CHAIR: Thank you.

Senator URQUHART: One of the things that we're talking about here, Mr Ahern, is ketamine infusions. We're not talking about medicinal cannabis. I'm really interested in what alternatives are on offer for workers for whom you say a particular treatment is not acceptable and you've decided to not continue to pay for that. What alternatives are you offering?

Mr Scofield: I can't talk to the details of the particular claim—

Senator URQUHART: Are you offering alternatives?

Mr Scofield: Of course there are alternatives that would also be, I assume, a part of the current treatment plan. There would be a range of different treatments directed, and there may well be alternatives offered in the absence of particular treatments where the effectiveness is being questioned. There are a lot of different treatments around. Some are quite experimental, and for some the effectiveness is open to legitimate question, but I don't think I can go any further into the specifics.

ACTING CHAIR: Yes. We will actually need to leave it there. Thank you very much for your participation today. We really do appreciate it.

LANE, Mr Dominic, Commissioner, ACT Emergency Services Agency

WREN, Mr Howard, Chief Officer, ACT Ambulance Service, ACT Emergency Services Agency

Evidence was taken via teleconference—

[12:21]

ACTING CHAIR: Welcome. I understand that information on parliamentary privilege and the protection of witnesses and evidence has been provided to you. Would you care to make an opening statement? Then we'll ask you some questions.

Mr Lane: Thank you; I would. My statement parallels the written submission I provided to the committee. Thank you for the opportunity to present today. My role is Commissioner of the ACT Emergency Services Agency. I am accountable for the service delivery of emergency services to the national capital across four operational services. As such, I am responsible for the safety of the staff and volunteers across ACT Fire and Rescue, the Rural Fire Service, SES and, uniquely within the Australian context, I can quite proudly say, our ACT Ambulance Service, which is also a part of our Emergency Services Agency. I would like to discuss today, in the context of my career experiences, observations and thoughts, what has changed but also, in the context of why we're here today, what has not changed, which will then take me to why I've implemented the strategic forms I have within our particular agency.

I would also point out, though, that mental health of emergency services workers is not simply a matter for me and my colleague chief officers to deal with alone. As a portfolio agency within the ACT Justice and Community Safety Directorate, we have the support of the broader directorate as well as the support of the broader ACT Public Service through the Chief Minister, Treasury and Economic Development Directorate. In appearing here today, though, I cannot do so without drawing on some of my own personal reflections.

In considering the past, I in no way wish to diminish the challenges our contemporary front-line emergency service workers face, the dangers they are exposed to, the challenging circumstances they confront, and, of course, what they see on a day-to-day basis that members of the community may never witness in their lifetimes. When I started to get heavily involved as a volunteer in my local bushfire brigade, it was a very different time with very different attitudes to mental health, but maybe in some ways some of those things were actually not so bad. I recall the Australian movie *Crocodile Dundee*. Some of you might remember the scene at Walkabout Creek when the American journalist is talking about seeing a shrink and Mick Dundee says, 'What's a shrink?' She explains what it is, and he says, 'In that case, that's Wally.' You might remember the John Meillon character. 'Everyone in town tells Wally, and he just tells everyone else, and there's no longer a problem!' Possibly there's some good consideration to that, because, as emergency service workers, that's probably something we haven't been good at doing.

Back in the eighties it was not uncommon for handfuls of volunteer firefighters to die every year. Ambulance paramedics and firefighters in country New South Wales that I observed, particularly along the major highways, were called to numerous horrific road trauma incidents. Many of these became my colleagues and friends, and I could always see they carried heavy burdens from what they experienced. Fortunately, times have changed. Our firefighting practices are much safer and we are certainly better resourced. Our roads, while still dangerous, are much safer than they were in the past.

As I became a manager during the 1990s, we started to see concerted efforts towards the recognition of PTSD and we started to discuss what was normal and how to react in an adverse event. We started to consider the initiatives such as chaplaincy services and the post-incidence peer support programs. Whilst we've moved a long way from there in terms of our efforts, in some ways, of course, we still haven't got it right. So, whilst there have been significant changes in terms of the physical safety for firefighters and paramedics and we've worked really hard in relation to addressing the physical injuries our firefighters and paramedics are still subjected to, we are much better in that area than we probably are when it comes to psychological injury.

Whilst we know what has changed, I've reflected a lot, as part of this process, on what hasn't. We are still uniform services. We are very proud of our uniforms in the case of my organisation—that's five separate uniforms—and we are proud of the strong identity that sits behind that. We'd like to see ourselves, quite rightly, as different from normal public sector jobs. Our traditions and industrial structures mean we rarely promote people from outside our services into front-line roles. We like to think of ourselves as diverse, but for some of our services we have continued to recruit in our own image. Our front-line staff aren't exposed to other opportunities, other roles within government, until it is all too late. And so, by the time someone needs a break from the challenging role they undertake, they themselves are not in the position to feel like they can do so, and we as organisations traditionally have not been prepared to accept how to actually do that. Whilst within the ACT

government context we are one public service, it's very hard for our front-line personnel to see them as part of that.

We've done a lot within the ACT over the last few years, and I'll get Howard to talk a little bit about the specifics of the mental health programs we have been working on, but I just want to reinforce to the committee that this cannot be dealt with as a simple strategy or as a stand-alone thing. It has to be dealt with in part of your overall organisational management. One of the reasons when we set our new mission as the Emergency Services Agency back in 2015 was not simply working to care for and protect our community but working together to care for and protect each other. That is one of the strong messages we have been trying to get through. The organisational change we've been through to create an executive specifically responsible for people and culture has not been without controversy within the ACT, but it is not until you actually start to resource and function at an executive level the things that you need to do that you are going to have any chance to address the issues that we face. We continue to build on that function through the promotion and the engagement of our manager welfare programs, which have been very successful positions that have gone into the agency to help us with a specific focus and a priority on our ambulance service at first but are already and very quickly starting to move to support the rest of our agency.

We continue to work on the mental health training packages and particularly some of the key ones that Howard will outline in a minute. Under our agency, one of the key programs we've been working on is our blueprint for change. It's recognised that the agency needed to change in relation to how it engaged with staff, and we still have a strong challenge there. Working with 24/7 front-line workers is challenging for people in our office based environment, and it's something we work even harder to do. We'll continue to work in relation to some of the programs such as the peer support element, which we'll talk a bit more about in a minute, but, most importantly, we'll also continue to work across government because that's a unique advantage we have here in the ACT by having all four emergency services under one agency and also being one part of one public service. We will certainly be taking that down the track. I am happy to take questions on that but am happy first to possibly pass the focus to Howard to talk about some of the specifics of some of the mental health programs we have been working on.

ACTING CHAIR: Go ahead.

Mr Wren: As you said, Commissioner Lane touched on us being in a somewhat unique position as an ambulance service, in that we're embedded with our emergency service colleagues as opposed to being aligned with the health department. Without going into some of the more controversial aspects of that relationship, it has benefited us significantly in the recent changes that have occurred across the broader ACT Emergency Services Agency.

We are now the recipients of the program that Commissioner Lane mentioned, the initiative to place a welfare manager. We are the recipients of a range of programs that have been tried and tested in other ambulance services, in particular the peer support program which was modelled on the Queensland ambulance program of longstanding and high regard. More recently, a program was imported, with slight local modifications, from the Victorian ambulance service. Its acronym is MANERS, and it focuses very much on individuals and small teams looking after their own mental health and emotional wellbeing.

Commissioner Lane also mentioned the blueprint for change. I suspect that many of the submissions you've heard have had a reference to how organisations—and, in particular, I refer to ambulance services—have managed themselves internally in terms of culture, management and organisational behaviour. As a result of a significant review of this within the ACT Ambulance Service several years ago, we have the ACTAS Blueprint for Change. That has been implemented across the whole of the ACT Ambulance Service, and some elements of it are now being looked at across the wider emergency services authority. I think that while this is an emerging process and, necessarily, is slow and incremental in some areas, we're very much the beneficiaries of this approach.

ACTING CHAIR: Excellent. Thank you both very much for appearing today. I've asked this of a number of other witnesses: from your point of view, Mr Lane, what good evidence is out there that shows what works in a preventative sense? How much more can we build into the preparatory work and into the education system to build a greater level of resilience? Obviously, once we get to the point where people have PTSD then we're in a very difficult situation. We heard from an earlier witness that the breakdown, from their point of view, was 'a third, a third, a third': a third of people never really get adequate treatment and can't be treated adequately. Obviously, we want to do everything we can not to get there. What do you think about that, and what evidence is out there? What can we do to build more resilience into the system?

Mr Lane: I probably wouldn't be sitting here if I had the answer to that question as such, because that's the question we've all been asking ourselves. I do think it gets back to the fact that people work very hard to gain a role as a paramedic or as a firefighter. You can see just how proud many people are—and I've spoken to plenty when they start the role at the education level through recruit colleges, inductions and the like—that they've made it this far. When you go to a graduation, you see them there with their family and friends; everyone is so proud because, in many cases, they've attained their lifelong dream.

So, of course, it becomes very challenging when that dream job starts to unfold. In my mind, I'm not sure the answers lie in things like psychometric testing, recruitment screening or anything like that in the front end because I think that's just too hard. I don't think there's any system in psychological analysis that could actually take people through it, because so much depends on the experiences that they then have as they go through. What we have to do better, of course, is to recognise—as we're starting to—that this is a risk to the business, and that this is a safety risk to our own people; people will be exposed to this.

As I said, we've got a lot better at that over the years. What it's about for me, and what we've started and seems to be working, is positioning under the 'working together' model. You might be a firefighter within fire and rescue, but if you've had a bit too much of the job and you need a bit of a break from it, or there are other things that have come along in your life and it's time for a change, let's make sure we're ready for that. Let's make sure we're at the front end of that. And recognising that whilst we've had a traditional competitive rivalry across our four services, because of the different cultures they come from, it is okay to step out of that role and step into another. If a firefighter goes and works for the State Emergency Service or an ambulance paramedic goes and works for the RFS, as we've had in recent times, traditionally that might have been seen as very out of the norm and extremely unusual, heaven forbid, to even take a public servant role. People are now starting to do that. I think that can lead to benefits in relation to what I believe is most important when it comes to mental health and that is that people have options in relation to the confronting situations which they face. Unfortunately, our people in the past felt that they haven't had options, and we probably haven't been good at providing them.

I don't think I can answer the question at the front end, but I think it's the systemised process through a person's journey in their career. Some people will be happy to be a paramedic for the rest of their lives. I know in certain recent discussions we're dealing with a very changing generation of people coming through that don't necessarily think that way. I think it's incumbent on us as employers to make sure that we're helping people to consider what options there are, because we've got some very talented people who have come into my agency that could also work in many other parts of government as well.

Senator MOLAN: To follow on from that question, does the last bit of the points that you made, Commissioner, apply to your volunteers as well?

Mr Lane: Indeed. Whilst it's slightly different in relation to what we can do in terms of employment, we have had situations where we've employed a volunteer with a physical injury, who couldn't do their day-to-day labouring job, in the agency or into government in other ways. We have a very strong, we believe, and supportive workers compensation system, which, as we know, is always subject to the challenges that the hearing has been discussing. But we very much treat our volunteers in the same way that we treat a staff member. We can't go to the point of career managing them, in terms of if they have another role within the APS, in the private sector or whatever but certainly we treat volunteers with what I would like to think is the same respect and the same consideration as we do our own staff.

Senator MOLAN: From being a member of your RFS, I see the difficulties in ever assessing any of us volunteers as we come in. And I think that's the experience of the military in that the psychological testing we do tests only your ability to learn and to survive recruit training. From then on you build teams and you support each other from teams. But I'm not here to give evidence, Chair!

Mr Lane: On that point, I think it's a really good one. One of the things we benefited from in recent years is recruiting people from defence. The ACT government has a strong priority here within this town of making sure that as people come out of the services, and sometimes with their own challenges or whatever, we can be a welcoming employer, and it helps us in terms of our own diversity. Once again, we get extremely talented people with a great deal of training—sometimes in command functions, sometimes in operational functions and sometimes in relation to planning or whatever it may be—that can certainly help us. We're very much latched onto the fact that some of those people are coming out. It's important for us, as part of that, to recognise they are different because they've come from a very different culture to ours. Even though we're in uniforms, believe you me it is very different. In our accepting of that we have to take that into consideration. Certainly, we have a lot of volunteers who aren't ex-defence personnel, which we welcome into our ranks—

Senator MOLAN: Or current defence personnel—

Mr Lane: In many cases also current serving. We learn a lot from our volunteer organisations through the diversity that our volunteers bring, particularly here in a place like Canberra, where people can come from very different roles. Some of those people bring their own levels of expertise on this very issue.

Senator MOLAN: The other question I have relates to the uniqueness of your position. Whatever the change is in cultures that we've to do—with someone who may have had a traumatic experience—as previous witnesses have said, if you add to that, perhaps, a workplace where there might be a bit of bullying or other stresses like that then it compounds. We've certainly had that in the military. Whatever the changes that go through the workplace must start at the top. But your ability to direct all the emergency services must be quite unique—and it's in Victoria as well, isn't it? I think you have an equivalent in Victoria, or is that purely a coordinated function?

Mr Lane: There are slightly different models around the country. In my particular function, yes, I probably have a stronger command-type function, for want of a better word, through the legislation. But—and this is one thing I really want to reinforce, because you've raised a really good point—when we established our strategic reforms, one of the principles we established under that was that we would always respect the identity of the individual services but we would operate as a coherent whole. That's something we've stood behind. Sometimes there have been questions: 'Commissioner, if you're one agency, why don't you just have one uniform?' and all those sorts of things. I personally don't believe in that. I personally think that when you've got a paid firefighting workforce, you have a very specific function to do. Our paramedic workforce and patient transport personnel, our volunteers of the Rural Fire Service and the SES—you can't just bunch it altogether. From a mental health perspective, I certainly don't think that would help.

We work very hard to make sure that we've established what we call the enabling functions that sit behind it. In the back office, I expect not to create four different HR teams or four different—and that's where we suffered in the past. You bring them into a coordinated function so that our chief officers can very much get on with their work in terms of leading from the front within their four operational services. That's the way we've approached it. Whilst it's unique, as you say, in terms of the function that I hold, my colleagues as chief officers are equally critical to that as well.

Senator MOLAN: Are you seeing anything that you can specify as to results of your cultural change?

Mr Lane: I would argue it's more about bringing it together at the back end. It's very much about leaving the four operational services to get on with their roles and recognising that the chief officers can't be across finance, mental health, procurement, strategic planning and all those things. That all needs to be done at the back end. The team I've got at the back end that helps these four officers to do that allows that to occur seamlessly so that people at the front end—firefighters, paramedics, volunteers—can't see any difference. As long as they're getting the services they need, that is the main thing from my perspective.

Senator URQUHART: You mentioned the manager welfare positions. Can you tell me how long they've been employed in the role, and what, if any, change has there been in the experience of both staff and volunteers around psychological injury?

Mr Lane: I don't know if we've got there, in terms of fixing psychological injury. But the position of manager of welfare programs was an election commitment of the ACT government in 2016. We immediately got on with the appointment of that and had the person into the function in early 2017. We've been very fortunate that the individual that's undertaken that role has fitted into the organisation very well, in terms of being visible, approachable and someone that the organisation can see is actually serious about the job. But, more importantly—and what sits behind that, as Howard said—is, through our program of reform, we've been able to work through the actual implementation of those programs.

Getting to your point about the peer support program, the feedback I've got from our ambulance paramedics has been outstanding. I must admit that when we first started the peer support program I was a little bit sceptical, in terms of: you need to make sure you've got high levels of trust and confidence and that you build the right people into that team. The manager welfare program, which is working with our Queensland colleagues, has assured me, from what I've seen, that that is not a question at all. We've ended up with a fantastic program. I think we've got some 26 peer support officers, 10 per cent of the ambulance service in those trusted roles. The feedback I've had from paramedics around that has already been outstanding. That has transformed across to our State Emergency Service, where I think we've got 11 peer support officers in that role.

Senator URQUHART: That's on top of the 26?

Mr Lane: That's correct. There's now a keenness and a willingness across the RFS and ACT Fire and Rescue to expand the program. We've got to be careful how we do that, because it's got to be accepted by the cultural norms within the agency, but so far it's been very good. The MANERS program has been one of those ones that I

believe, based on the feedback—and I think the MANERS program comes out of Victoria, Howard, from memory. It's one of those age old things—

Senator MOLAN: What does that stand for again?

Mr Lane: I'll bring it up. Have you got it in front of you, Howard? I've got it here.

Mr Wren: It's an acronym for minimise exposure, acknowledge the impact of the event, normalise the experience, educate as required, restore or refer, and self-care.

Mr Lane: I believe—that first one about minimising exposure—if you don't need to see it, don't be there. Obviously, some people do; it's part of our job. But it's about taking people through that system. One of the other things that have been really well received is the mental health first aid training, and particularly—

Senator URQUHART: I was going to ask you about that. How many staff have completed those courses? Are they mandatory, and what changes have you seen as a result of these courses?

Mr Lane: Howard, you can go to the detail. But, certainly, it was an in-service program for everyone.

Mr Wren: For MANERS it was, yes, within the ambulance service, and it's now being looked at for a broader ESA rollout. The mental health first aid is not predominantly aimed at paramedics, because it is essentially first aid, so it has more input into the other agencies. So I can't really speak to effectiveness, but, in the first instance, it does two things: it makes people a little bit more aware of themselves and their own mental health and emotional wellbeing, and, also, it gives them some ability to monitor their colleagues and their teammates.

Senator URQUHART: Peers keeping an eye on one another.

Mr Wren: Yes. But, I apologise, I can't tell you off the top of my head how many people have been through the program.

Senator URQUHART: That's alright. If you want to take that on notice, that'd be great—the percentage overall. Is the ACTESA involved in national peak bodies?

Mr Lane: Yes.

Senator URQUHART: If you are, can you comment on not only how you're learning lessons from the bigger states but also maybe what you're teaching them, particularly around workplace culture, support for staff and training for managers? I'm interested in that.

Mr Lane: Certainly. Across that, the ACTESA is involved with what I believe are the two main peak bodies. One is the Australasian Fire and Emergency Services Authorities Council, AFAC, and I am a member of AFAC. The other is the Council of Ambulance Authorities, of which Howard is a key member. We are involved in many other ways through other key initiatives. Howard has a very critical role at the moment in terms of the registration of paramedicine. Howard sits on the board of that process. I'm involved through the Male Champions of Change project, and that's something that within the ACT we've taken the lead on by being the first fire and rescue agency to put a target process in place, for women, to recruit firefighters, and we've taken a number of other initiatives through the restructure of our organisation to remove what I call 'uniforming up', and that is that, if you have to come up through the ranks, you'll always end up with the same sorts of people. That is no disrespect to anyone who has been in those roles, but if you don't open up opportunities for people from outside you never get the opportunity to bring in women senior leaders or people from other backgrounds and the like. So we've done a lot of work in that space. We closely collaborate, through the AFAC system, as a contributor to the Bushfire and Natural Hazards CRC. We're obviously a financial proponent of the beyondblue survey that you would be aware of through your conversations with the CEO there.

Senator URQUHART: To be released a bit later this month, I think.

Mr Lane: That's correct. We've been a close partner on all of those things. We work very hard to stay engaged. It's sometimes challenging for a small jurisdiction to be across absolutely everything and anything that's going on in that space. But the benefit we've had by having an executive in the people and culture function, and a manager in welfare programs as well, means we're sending the right sorts of people to those meetings and drawing on the lessons and collaborating much better than we've ever done before.

Senator URQUHART: What's the relationship like with the AFP in this space?

Mr Lane: We have a close relationship with ACT Policing through the nature of the business that we do. The new Chief Police Officer within ACT Policing, who's just about to start, will bring with him his own experiences through working with Commissioner Colvin as part of the reform team there. So we very much look forward to the good work that they've been doing. We've obviously had a close relationship with the previous chief officer, Justine Saunders, who has just moved on. Basically, whilst we don't share close information, because the

employment arrangements are very different because ACT Policing is a contracted entity under AFP to the ACT government, we still maintain those close links. Our closer links are with our other directorates: the environment directorate, Health, Chief Minister's and the like. We have a very close collaborative model through that.

Senator URQUHART: One of the main concerns we've heard about ambulance services across the country is that they're run a bit like paramilitary organisations when you have trained health professionals who need the freedom to take calculated risks and make informed proposals at the time. Can you take us through how you're changing that culture and particularly what you're doing to equip the middle managers with greater skills in both this area and in managing the mental health within their workplace. Also, I'm interested, if you're aware, of the work by the Black Dog Institute of New South Wales, the university, with the New South Wales fire and emergency services. We heard some evidence in Sydney around that.

Mr Lane: We've done a bit of work ourselves with Black Dog. The term 'paramilitary' is a really interesting one. Coming from a volunteer background, I hadn't seen a uniform until all of a sudden they told us we had to start wearing uniforms. It wasn't what we did. If you look back into the history of ambulance, to some extent, even though we've all had uniforms of some sorts, the insignia, rankings and badges seemed to come a little later for some of our services. Some traditionally, such as our urban fire services, have a strong and proud history of that. I think what I see, my observations—and Howard can turn to it from a paramedic perspective in a minute—is that the world has moved on from these old command and control structures and we haven't quite caught up as emergency services with that. It's not what millennials want to see—how we engage with our new staff coming through. I think that is a bit of a challenge for some of our very good middle managers that have done a fantastic job, but the world's changed around them.

We are doing some work, particularly within the ambulance service, in relation to working with our union about different models that we're going to bring forward in terms of frontline supervision, performance management, opportunities for professional development and all those sorts of things to get a lot more organised—and I'm a strong advocate of that. As I mentioned before, that's been a tough space for us. The tough space between the normal day-to-day worker at the higher levels of the organisation and people that work on shift under the 24/7 environment is always very challenging. Did you want to comment on the paramilitary—

Mr Wren: Notwithstanding my appearance on the day—

Senator URQUHART: I wasn't casting any aspersions!

Mr Wren: looking somewhat pseudomilitary, I think appearances can be deceptive. Whilst we do have a somewhat hierarchical structure, it isn't what you would describe as rigid. You made the point about health professionals making their own decisions and being autonomous, and I think it's still the case that most paramedics, day to day, case to case, work with a great deal of autonomy and that's valued and in fact encouraged.

The point about middle managers and how they function, I think, comes back to a point that Commissioner Lane made that we now have a workforce with different expectations. I started in this line of work in 1974 and, to be really honest, we didn't have much in the way of expectations in 1974 except for a roof over our heads and a kettle. Without question, our workforce has changed dramatically. There are different community expectations—they're exactly the reason that we're all here today—and very much different expectations in our workforce. The point that Dominic just made about making some changes to the structure and working within the enterprise agreement to facilitate that is very, very important. It will provide our frontline supervisors and managers with some additional capacity and support to best meet some of these, without question, previously unmet needs. It is a highly evolving process.

Senator URQUHART: Thanks very much.

ACTING CHAIR: Thank you both very much for your time today. We really do appreciate it. Unfortunately, we have a very packed agenda for the day, so we will need to move on to the National Audit Office.

BRYANT, Mr Paul, Executive Director, Performance Audit Services Group, Australian National Audit Office

RAUTER, Ms Lisa, Group Executive Director, Performance Audit Services Group, Australian National Audit Office

[12:54]

ACTING CHAIR: Welcome. I understand that information on parliamentary privilege and the protection of witnesses and evidence has been provided to you. I have to step out part-way through this session but Senator Molan will take over as chair, and I'm sure Senator Urquhart has lots of questions. Would either of you like to make any opening remarks before we ask you some questions?

Ms Rauter: No.

Senator URQUHART: I want to go to the audit of the AFP. Can you comment on the implementation of the recommendations from that recent audit? Have there been issues that the AFP has sought further assistance with?

Ms Rauter: The AFP agreed with all of the recommendations as outlined in the audit report but we have not gone back in to follow-up with the AFP, in terms of the implementation of those recommendations, as yet.

Senator URQUHART: Is that something you would normally do?

Ms Rauter: We don't do it on every single audit but we do have a process of looking at follow-up audits in different portfolios. We would generally give them a bit of time to implement recommendations before following up.

Senator URQUHART: I understand that the AFP has attempted to address in its health strategy, released shortly after the audit report, some of the concerns that the audit found—so it has looked at that. Have you read the AFP's recently released health strategy?

Ms Rauter: I haven't.

Mr Bryant: No, sorry.

Senator URQUHART: I was going to ask you if it went far enough in addressing the concerns but, if you haven't looked at it, you probably wouldn't know.

Ms Rauter: It is something we would look at if we went back and did a follow-up.

Senator URQUHART: Would you be able to have a look at the AFP health strategy and come back to us, on notice, on whether you think it has addressed the concerns that were raised in the audit?

Ms Rauter: Certainly.

Senator URQUHART: We've got a number of witnesses that recommend a presumptive PTSD model for workers compensation for first responders as a way of tackling the issues around withdrawal of claims and the claims process, which can cause further psychological distress. I understand that the WA Department of Fire and Emergency Services has an understanding with its insurer to manage psychological claims in this way, and that that's an approach that doesn't need legislative change. Did the ANAO examine such an approach with respect to the AFP and Comcare?

Mr Bryant: We didn't, no.

Senator URQUHART: Why wouldn't you have looked at something like that?

Mr Bryant: What we were more concerned with, I suppose, was what impact the management or otherwise of mental health within the AFP had had on Comcare claims. We have a separate audit planning process that won't look at a potential performance audit—topics around Comcare and that area. An audit into that area might look at potential reforms, but we tried to keep our scope specifically focused on what the AFP—

Senator URQUHART: So is that something that the ANAO would look at in further audits around the AFP; other models and how they might help with psychological claims particularly?

Mr Bryant: I think there's a definite value in looking at it. As you said, it's early days in terms of getting data. We'd want to allow a sufficient time period for us to have data and evaluate it. I think what they've implemented is something quite different, and, therefore, it should be looked at.

Ms Rauter: If I can just add to that: each year we do develop an audit work plan for the year ahead, and that is open for not only public but also, particularly, parliamentary consultation. If there's a topic you think we should be looking at, there's an opportunity for you to propose that.

Senator URQUHART: Maybe this committee could propose that; I know we have input into audit stuff. Have you got any idea about what learnings other state and territory based first responder organisations could take away from the report into the AFP? Is there something that jumps out that you think other organisations could learn from?

Ms Rauter: To summarise where we landed at the end of the report, the AFP had numerous different services and support structures in place for employees. There was quite a lot of investment in that; that was not done lightly. The gap that was missing, which is important for other first responders, was making sure that they understand where the risks are and where each employee is at as an individual. Because of the gaps in the record keeping, the gaps in linking between accessing one service and another service and the disparate records that were kept, there was no centralised understanding of what the individual officer needs were, and making sure, therefore, that they were supported at that individual level and, as an in-between measure, making sure that the culture of the AFP more broadly was of a nature that enabled supervisors to identify where there was mental health risk and to then link those people into those support services that were available.

Senator URQUHART: You mentioned the general culture of the AFP. Can you just explain that to me?

Ms Rauter: What we found through our interviews—we interviewed 102 AFP officers through the audit process—was that, while the support services were there and people generally knew that they were available, people were uninclined to access those services because they thought it might affect their career progression or how they were viewed by the organisation.

Senator URQUHART: Was that particularly pointed at any level within the AFP or was it a generalised statement? In other organisations we've had before this committee, there seems to be a real commitment from the very top level to deal with psychological and mental health issues, to try to address them and reduce them and help people, but there seems to be a barrier somewhere at the middle level. I'm not having a go at that middle management level; it's more about the tools that they've been given to deal with the issues.

Ms Rauter: I think that's probably right. I don't have the data in front of me as to the level of officer that gave that particular type of feedback. I don't think we even captured that or recorded that. Did we, Paul?

Mr Bryant: I can talk to it briefly. The equivalent level in the AFP that you're highlighting there is the supervisor level. We did look. Basically the Phoenix data, which we highlighted in the report, was based on and aligned with what came out of the 102 interviews and 60 submissions that we got through the process. It highlighted that, in the first instance, your supervisor is the person who is responsible for managing your welfare; that's a legislative responsibility. People were fairly unanimous in saying that that was the last place they would go to, in the event of a mental health difficulty. I think that's a real challenge that all first responder—

Senator URQUHART: Was there any expansion on the reasons why that was the case? Was it because of a lack of distrust, or was it a lack of ability to deal with the issue? What was it?

Mr Bryant: I think it was a bit of both. There was, firstly, the cultural issue, which we've highlighted already. The second issue that we highlighted was: there's no specific training curriculum for supervisors in how to manage mental health. This is not an area that is acquired through experience. The other jurisdictions that we looked at—Queensland, for example, and Victoria and the like—are developing training courses, et cetera. We recommended that the AFP do the same thing, aimed at that supervisor level, to equip them in how they should be approaching the issue.

Ms Rauter: You mentioned trust. One of the issues that came back through those interviews was a lack of confidence that the information that they shared would be kept confidential. So that is a trust issue.

Senator URQUHART: That's been a pretty common thread throughout this inquiry; the reluctance of people to share information about their private issues because of that lack of confidentiality. Of the 102 officers that you interviewed, are you able to provide us with their rank or level?

Mr Bryant: We can take it on notice. We can provide a breakdown.

Senator URQUHART: There are six recommendations that the audit made:

The AFP develop a comprehensive organisational health and wellbeing strategy …

… … …

The AFP analyse, define and report on mental health risks across the organisation …

… … …

The AFP implement a mandatory mental health training framework for all AFP employees …

And they go on. It's pretty damning of an organisation like the AFP to not have that stuff in place. Did they have any level of that in place?

Ms Rauter: As I sort of said earlier, it's really a matter of bringing this up so that there's really good visibility and transparency of the issues in one place. There were training courses available but not on a regular basis and certainly not for all supervisors. It wasn't a mandated process.

Senator URQUHART: It was pretty ad hoc.

Ms Rauter: They didn't have records as to who had been on that type of training and who hadn't. There certainly are processes in place to assess officers' suitability for certain high-risk roles, but again they weren't implemented with a stringent approach. It was mandatory, but there weren't records kept all the time, and some officers slipped through the cracks. I'd say there were structures in place—it certainly wasn't something that was ignored by the organisation—but the recommendations are really about bringing that together so that the frameworks are much more robust, much more tightly managed and better records are kept and better reporting is in place so that there is that central knowledge about where the risks are and whether the mitigation strategies that they had in place to deal with mental health issues were effective.

Senator URQUHART: I want to go back to my first question, about the implementation. We know that the AFP agreed with the recommendations. I think you said that they hadn't come back to you or hadn't asked for further assistance. What sort of time frame would you expect for an organisation such as the AFP to be able to implement this stuff and come back to you and say, 'We've done what you recommended'?

Ms Rauter: We would generally think in terms of what we think is a reasonable time for us to go in and do a follow-up audit. It's usually about two years, as a rule of thumb. It really depends on the nature of the recommendations. Sometimes our recommendations are more urgent in terms of the implications of not, in which case we might expect it sooner than that. Sometimes we specifically say, 'You should immediately look at this,' where we think something has to be addressed straightaway.

Senator URQUHART: Can you just take me through the six recommendations and tell me what the urgency of those is, from your point of view?

Ms Rauter: In terms of recommendation 1, which is their strategy, they certainly were in process on this. In 2016 they had a draft strategy. It just hadn't been agreed. They were actioning that—

Senator URQUHART: So for two years?

Ms Rauter: Two years. We think that they just need to finalise that, bed that down and have some actions against that. Given there had already been quite a lot of work done under that, we would expect that would be done relatively soon, certainly in the following financial year.

In terms of analysing, defining and reporting on mental health risks in the organisation in a consistent manner and developing arrangements to align employee mental health and wellbeing resources to areas assessed as the highest risk, again it depends on the systems and perhaps the technology that they might need to embed in place in order to get access to all the right data and have that centralised. Sometimes that can take longer and sometimes it might take a while to actually reassign your resources. It all comes down to the risk that the organisation itself decides to place on not addressing those particular recommendations. Something like that might take a bit longer, because you might need different IT tools and things like that to embed in place.

Recommendation 3 is around a mandatory mental health training framework. I would suggest that, given the risks that are in the organisation, that one should be addressed within the financial year. But it may take longer in that they may need to design a training framework, tender for it and those types of things. But, in terms of starting some action to progress that one, you would expect to see something relatively soon.

Recommendation 4 is about formal processes to monitor and provide assurance that employees in specialist roles have psychological clearance in place and that mandatory mental health assessments and psychological debriefs are undertaken. The problem was serious but didn't involve many officers, so I would expect that should be able to be implemented relatively easily. They had the frameworks in place; they just weren't necessarily all being implemented on a consistent basis, so that should not take a long time to implement.

The AFP, in reviewing—this is recommendation 5—available support options, used a risk based approach to determine the optimal risk mix of services to target identified organisational mental health risks. There were three parts to that. That may take a little longer. One of them particularly is around culture change. Culture change doesn't happen immediately; culture change does take quite some time.

Senator URQUHART: But it doesn't happen without things being implemented.

Ms Rauter: It doesn't happen without specific action and messages from the top reinforcing that at all levels of the organisation. You want to see progress on a recommendation like that, but it may take a while to embed.

Recommendation 6 is to consolidate the disparate systems and hard-copy records and also establish a strategy for analysing employee health information against data. Again, those types of processes are probably technology related and so may take one or two financial years to bed down, but you would want to see a start.

Senator URQUHART: The inquiry's terms of reference talk about return to work and post-retirement support. Your report into the AFP didn't make specific recommendations within those areas. Could you speak about your research and findings, around return to work and post-retirement support, that can support the committee's work in this inquiry. Are there any specific changes and reforms to return to work and/or post-retirement support that first responder organisations should look at?

Mr Bryant: It's a very good question. Basically it wasn't within our scope of work to look at it, but if you refer to paragraph 4.29 onwards, you find that we do talk about support for former AFP employees. The Comcare data highlighted—this is on page 57, if you're having a look—that since 1989 there have been these sorts of periods where psychological claims from former employees have increased and then been addressed, but most recently they've increased to a substantial high of around 12 per cent of the total. We recommended that the AFP look at its exit interview or departure processes. This was a key theme that came through in the submissions as well. We got a number of submissions through the public facility from former employees saying that as part of their exit process they would have loved to have received information on what they can access post their AFP career. The AFP provides ongoing services that that these individuals can access post their career.

Senator URQUHART: What sorts of services?

Mr Bryant: For example the AFP last year reported the organisation of a health triage service that they'd recently implemented, which could be accessed by former employees. They're still doing some work in that area, but any information that can be provided—if you contrast this to the Defence environment, who have a specific department for this, we found that the AFP didn't provide anywhere near the level of support. That's potentially something that could be looked at in a separate audit.

Ms Rauter: One of the more recent initiatives that they took on, though, to assist both current and former employees is an app to help people self-monitor and track their own health and wellbeing, including mental health. That was called equipt. We talk about that in paragraph 4.20 of the report. There are some measures in place to indicate to us that they were trying to address that issue, but there's always more that can be done.

ACTING CHAIR (Senator Molan): Out of interest, have you gained data, from any of the organisations that you've audited, on bogus claims? I'm trying to understand why some organisations have an adversarial relationship. I could only imagine that is partially driven by what they see as the profit margin or looking after taxpayer money. We discovered in the military that it was much cheaper to get rid of that risk altogether and not consider it than to try to make an issue of it. Have you been exposed to that in any of your inquiries?

Ms Rauter: To my knowledge of the ANAO, which is not that deep, I don't know whether we've gone in and looked at Comcare and their management of fraud, which is essentially what you're asking. To my knowledge we haven't necessarily looked at fraud. We have done audits of Comcare, though, so it might be something I'd take on notice for you and see if that's something we have looked at.

ACTING CHAIR: That would be great. Have you had any exposure to the Queensland Ambulance Service, who seem to be regarded as something of a paragon that others should strive towards?

Ms Rauter: We haven't. We did look at the Queensland audit of mental health in their own police force in pulling together this, but we didn't look at the Ambulance Service.

ACTING CHAIR: Can you give me a view over time of what anecdotally seems to me to be a change in the attitude towards mental health and trauma. People have always been exposed to trauma, but we're now considering it much more seriously, which is a great step forward. Can you give me any information from the inquiries that you may have done over time on why we are doing that now. Why the change?

Ms Rauter: I think it's public awareness and discussion of the issue of mental health. Some relatively public mental health issues have been discussed and there are many more fora now to discuss those types of issues. Things like teenage suicide and other depression issues are now discussed in social media. People are more likely to recognise those issues in themselves and in another person and there are more fora now to be discussing those issues and identifying them as mental health issues. Beyondblue, Black Dog and a number of different community groups are now lobbying and being proactive in supporting people. I suspect that's part of it. There are more fora now and more active voices for people to talk about that aspect of it.

ACTING CHAIR: I guess in the past they were just quietly dysfunctional or self-harmed or suicided.

Ms Rauter: Or they left that type of employment and went to work somewhere else.

ACTING CHAIR: Do the AFP admit to some sort of post-retirement obligation? Mr Bryant, you mentioned DVA. There is a great commitment there. Do the AFP admit to this, or is it something which goes case by case?

Mr Bryant: They are fully aware that they have a legislative statutory requirement under the workplace safety act that if an injury, regardless of whether it is a mental health injury or a broader injury, manifests itself in a latent period but can be proven to have been caused by your employment with a particular employer then that employer maintains liability throughout. Mental health is one of those areas that the research we've highlighted in here is indicating is quite prone to manifesting two or three years post the event, as opposed to a car accident, where you have immediate acute trauma. Our research highlighted that, if individuals are being exposed to violent imagery, that might build up, then, when they leave, it's not until a year or so afterwards that the symptoms of the post-traumatic disorder manifest. That is causing organisations of all stripes to look at this; it's not just the AFP.

Ms Rauter: The AFP recognise it. That has come through in the types of services they're looking to offer.

ACTING CHAIR: There are no further questions. Thank you very much for appearing before us. Witnesses will be provided transcripts and be asked to come back if they disagree with anything in them.

Proceedings suspended from 13:20 to 14:01

BURGESS, Mr Mark, Consultant, Police Federation of Australia

CARROLL, Mr Mark APM, President, Police Federation of Australia

WEBER, Mr Scott, Chief Executive Officer, Police Federation of Australia

ACTING CHAIR: I now welcome members of the Police Federation of Australia. I understand that information on parliamentary privilege and the protection of witnesses and evidence has been provided to you. I now invite you to make a short opening statement. At the conclusion of your remarks, I will invite members of the committee to ask questions.

Mr Carroll: Between us, we have nearly 100 years of policing experience. As indicated in our written submission, the PFA is a national organisation representing 62,000 police officers from each jurisdiction in Australia. Our written submission was developed in consultation with all branches of the PFA, who have endorsed our presence here today, representing a collective view. That in no way diminishes the Australian Federal Police Association and Queensland Police Union's submissions, which primarily focus on their respective jurisdictions, and we are supportive of Queensland President Ian Leavers' earlier testimony to you.

Our submission takes a national approach and makes recommendations about the role the federal government could and should play in this important space. I do not propose to try and convince you today that the proposition of policing is tough on the body and tough on the mind. There are any number of academic studies done over decades that demonstrate the deleterious effects on those for whom policing is a vocation. You will note that we refer to many reports and reviews in annex A of our submission. In my opening statement, I would like to focus on three points that we believe this committee could recommend as a result of this inquiry.

Firstly, the federation recognises that there is no one solution to the issues of mental health. However, we do believe that governments and jurisdictions acting in isolation of each other will not advance any solution. It is a national issue and therefore requires it to be addressed on a national basis. Having the mental wellbeing of first responders as a standing agenda item at COAG is a good start. This would elevate the issue on the national landscape and provide a framework for a holistic national approach. COAG's remit is to manage matters of national significance or matters that need coordinated action by all Australian governments. We consider the mental health of first responders in Australia and government's response to it as a matter of national significance.

Secondly, we argue that COAG is the perfect vehicle to encourage, support and deliver harmonised state based legislation for workers compensation matters relating to psychological ill health, and by that I mean presumptive legislation and provisional acceptance of claims.

Importantly, our submission argues that the recognition of mental illness must be an acknowledged occupational risk amongst the ranks of all emergency service workers. This would facilitate early treatment, and we all know that early treatment means early recovery. Rather than forcing a sick officer to prove his or her mental illness or psychological injury was caused by work, we need to reverse the onus of proof. If the employer had to show that the mental illness was not caused by work, we believe that this would provide fairer and faster access to workers compensation benefits.

Provisional acceptance of claims would allow our members to access services immediately following an incident and maintain that support throughout any subsequent proceedings. Without presumptive legislation and provisional acceptance of claims, the usual bureaucratic roadblocks simply deepen the despair and the pain of the ill officer and his or her family. This is a situation across all jurisdictions, and it is simply unacceptable.

Lastly, no discussion on first responder mental health and wellbeing can ignore superannuation, especially the preservation age. We were thankful to learn that Prime Minister Morrison has jettisoned plans to increase the pension age to 70 years. If that had happened, the raising of the preservation age to access superannuation funds would have risen from the 60-years-of-age threshold, in our opinion. This would be a disaster for policing. When the Prime Minister was Treasurer the federation lobbied hard to resist any movement to raise the preservation age threshold. As the son of a retired New South Wales Police district commander, I'm sure the PM understood our very real concerns for what might happen to the mental health and wellbeing of officers forced to work on the frontline long after turning 60 years of age. I, Scott and Mark will be happy to take any questions that you may have.

ACTING CHAIR (Senator Brockman): Thank you, Mr Carroll. My apologies for being a little late and thanks to my colleagues for getting started without me. I appreciate the fact that you've addressed the terms of reference towards what we can do at this level of government. I guess there's possibly a hesitation from some people in this place about the benefits of moving towards a harmonised regime. If we had had a harmonised regime 20 years ago, would Queensland have taken the steps they've taken in advancing this ball down the field?

There is a risk that things become locked in place and aren't changeable enough. We have heard that there have been improvements in some places—some a lot slower than we'd like. Certainly from my point of view, it sounds like some places are probably doing it a bit better than others and there are some learnings to be shared. There isn't any hard and fast science in this area, and there's still clearly a lot of work that needs to be done. By locking in a particular approach everywhere, do we risk not trying new things to actually see what works?

Mr Carroll: I would say that in the last 20 years we've come a long way in our understandings about the psychological impact of police work, and for all emergency services workers. So I think the time is right now for us to actually herd the cats, so to speak, and I think the federal government has a great role, through COAG, in being able to do that. We know that with presumptive legislation, for example, there has been a commitment from the Victorian government to introduce that legislation. It will be many years, if that happens, for other states to follow suit.

We are now intimately aware of the problem that exists for our members in relation to the treatment of their psychological health, and we believe that mental ill health is not a life sentence for our members. Early prevention and treatment lead to recovery. We want our members back at work; we don't want them sitting in their bedrooms for two years watching *Ellen*, because that's just not going to help them. So we have a view that the time is now, is right now, for this harmonisation of legislation to deal with the psychological issues of our members. Too many bureaucratic roadblocks are put up for them when they make a claim. Claims management processes across police departments in this country have been poor. That is starting to change, slowly, but we still have many members complaining about the way that they are treated throughout that process. Scott, did you want to say anything?

Mr Weber: It's also about best practice, and that's where the Police Federation of Australia has come on board. A primary example of that is with the equipt app. I'm not sure if that has been raised with the committee before, but again it was our Victorian counterparts who took that down that path. It's an app where people can get early diagnosis and also help in regard to their treatment for mental illness. They worked with the police force. Now that is across the entire country, and that happened through all the police associations and unions working together. That collaborative approach is so intrinsically important.

We do have Dr Kevin Gilmartin's book here, if you need it, which we consider to be the bible in regard to emotional survival for law enforcement officers. New South Wales initiated that and then we shared it across all the other states.

I think the federal government, especially through COAG, has such a critical role in getting everyone together and having those conversations, because otherwise we will have states falling behind and we'll still have emergency first responders getting injured. Prevention is so critical—

ACTING CHAIR: Absolutely.

Mr Weber: and we just want to get that point across.

ACTING CHAIR: How do you think we are going in prevention—in equipping people from the start to be more prepared—but also in stepping in earlier to make sure that manageable issues don't become unmanageable?

Mr Carroll: The Police Federation of Australia was fortunate to be able to convince the federal government to provide $1 million to us, out of the federal proceeds of crime account, to run a stigma awareness mental health campaign throughout Australia, which will be launched next year. For the first time ever, there is a telemovie being produced that deals with an amalgam of stories from members across the country in relation to the kind of psychological trauma that has impacted upon them and their families, and I'll come back to the issue of families shortly. The telemovie is part and parcel of addressing the stigma in relation to psychological injury within policing.

ACTING CHAIR: How did that come about? What was the origin of that?

Mr Carroll: The origin was with then federal justice minister Michael Keenan. It's supported now by the home affairs minister, Peter Dutton. We were able to lobby for and secure that grant funding to produce a national campaign to address—

ACTING CHAIR: And that includes the telemovie, does it?

Mr Carroll: It does; that's right. There will also be information for families and officers about the impacts of policing and what that might mean for families and for the children of families. There will also be collateral materials, like posters in the workplace and that kind of thing, to get people to start talking about the issues that are affecting them.

In relation to families, I think that all police departments across this country need to come together. We call ourselves a police family, and that's all well and good, and that's cop culture, but, in relation to addressing the

psychological injury that occurs through policing, we need to embrace, in a far deeper and more meaningful way, the families of officers. For example, if you are a parent of a police officer, what kind of stress, anxiety and worry is that going to bring to you at night? Do you understand what's going to happen to your son or daughter in relation to hypervigilance? What is hypervigilance in the policing context? What will that do physiologically and biologically to you? It's the same as to being a child of a police officer. What does it mean when mum or dad is grumpy all the time? Do you understand the impact of shift work and rosters, and hypervigilance and what it does? What are the key things that should be happening for a police officer to address hypervigilance and what it's causing to them? What should they be doing? These are the kinds of things that we need to embrace within our family units so that we don't end up with a psychologically ill member getting divorced, being estranged from their family and not talking to their children. It just spirals out of control. We want to address that. That's why we were so thankful that we were able to convince the federal government to provide that grant funding, to start to have these conversations on a national basis with all of our members.

ACTING CHAIR: Related to the telemovie and following on from a question that Senator Urquhart asked an earlier witness: do your members give you any feedback about how they feel about the reality TV shows on policing? Are they a positive because they give people a bit better understanding?

Mr Carroll: If it's not made by the BBC, I don't watch it, myself. But some of those reality TV shows—our police departments have been involved in them. I forget the name of one in relation to traffic policing and talking to people who have committed traffic offences. I mean, it's television. Members get involved in it when they have to, if they're directed by their employer, but it's not something that they talk a lot about.

Mr Weber: Any awareness in regard to what policing is and what we actually do is great. In saying that, 20 years ago we used to watch *The Bill,* and then we would know two years later what would happen in New South Wales. Now we watch these reality shows, and they are sanitised. They don't show the full nature of policing, and on top of that they don't go through the scenario and the instant thought processes that occur with police. They don't highlight, as Mark was highlighting before, the hypervigilance and the adrenalin rush, and then after that job and that critical incident—

ACTING CHAIR: I wasn't really trying to get at whether they're reality—I don't think they are—but more whether your members see them as a net: is it positive that the general public gets that view of policing, or does it actually make it harder?

Mr Weber: It's a mixed bag—it depends. Some of your colleagues are on there. It's great. They're on TV and you can watch them. It does highlight the nature of our work to the community and it does increase conversations, but sometimes if you are going through some issues you don't want to talk about your job and don't want to talk about those issues. So I think it's fifty-fifty, but anything that puts it out in the general public is still beneficial in regard to these sorts of conversations.

ACTING CHAIR: It's a very minor part of this inquiry, don't worry.

Senator URQUHART: You talked about Victoria and the presumptive legislation, and I'm very pleased to say that Tasmania, my home state, is introducing that as well. In fact, prior to legislation being introduced, which will probably come in the new year, I think the direction has been for the department to accept PTSD cases on the presumption of the workplace, so that's a really good move from the government of Tasmania.

Mr Weber: Excellent.

Senator URQUHART: I read Senator Brockman's question as being national control, but we're not talking about national control, I don't think, and you're not talking about that either. We're talking about national coordination.

Mr Carroll: National coordination of leadership.

Senator URQUHART: Yes. I just wanted to clear that up because I think the difference between the Commonwealth taking over things and the coordination of what's happening around are two very, very different things. I just wanted to make sure that I was understanding what you were saying in terms of coordination, rather than taking over something.

Mr Carroll: That's very true, Senator. We're not asking the Commonwealth government to take over anything, but certainly we feel that through COAG there's a leadership role and a coordination role.

Senator URQUHART: I think the Commonwealth has a role to play in coordinating and looking at what's best in some areas and sharing it with others, because there's not always that process there.

Mr Carroll: That's right. There's a very big cost to the taxpayer in relation to psychological injuries.

Senator URQUHART: Can you talk us through some of the specific elements in the mental health guide and health frameworks that you referred to in your submission and how they will improve or mitigate the experience of psychological injury.

Mr Burgess: I suppose it all started around the Commonwealth funding through the proceeds of crime account, and it is all predicated on early intervention and getting people back to work. The whole program—in fact the whole funding—is predicated on that. We decided as part of that process that we would, I suppose, develop a whole suite of issues. Obviously, the telemovie is an integral part of that. As Mark said, the telemovie is being based on real-life stories of real-life police officers right across Australia, from every state and every jurisdiction in Australia, and it's being voiced over in many respects by psychologists. Getting away from the reality TV shows, when a particular incident occurs the voiceover would then talk about what effect that might have on the police officer, their family et cetera. So for us it's very much a learning experience for an officer and their family to understand what might occur as a result of a particular incident.

As well as that, we're developing some booklets that are more specifically focused at police, yes, but also at their families so that the families themselves can get a better understanding about why mum or dad, or my children or my partner might be acting in a certain way. One of the things we've worked on in the last few days was one of the quotes that came from our members who said, 'If someone had explained this to me earlier, I wouldn't have gone through these years of hell to get myself well; I'd have been able to have some intervention at the early stages and I wouldn't have caused the problems for my family,' et cetera. I think, as Mark said, the reality here is about helping the families and work colleagues understand why someone's mindset or their actions might change so it might spark something in you to think, 'Maybe someone needs to intervene and help.' So the sooner you put your hand up—and part of that is breaking the stigma, with people being not afraid to put their hand up; it's not career-limiting—then the sooner you're going to get assistance.

We're just trying to develop a whole suite of measures. Without going into deal, we're working on the next tranche of this, and what a web portal might look like that is fully accessible by family, colleagues and police officers and that's got a whole range of materials readily available, 24/7, to go in and see videos of issues around anxiety, depression, alcohol abuse, drug abuse et cetera.

Senator URQUHART: Just along those lines of the telemovie and the other frameworks that you've got and the equipt app, have you been collecting data on the effectiveness of those tools, for want of a better term, and any feedback from officers and their families on how successful they've been?

Mr Burgess: Part of the challenge with the awareness campaign—or one of the things we have to do with that, is actually do an evaluation for the department, and we're not at that stage yet of our stuff.

Senator URQUHART: So it's early days.

Mr Burgess: It is early days for that. Once the telemovie is complete and it goes out—the funding for this program ends on 30 June next year—as part of that process we've committed to do a number of things around evaluation, but it's also to explore the notion of helplines et cetera, which is where we're getting to now with the web portals and those sorts of things.

Mr Carroll: One thing in relation to the equipt app is that the Police Federation of Australia was able to equip all our branches so that it was rolled out across the country. Data is kept in relation to how many officers have accessed it, downloaded it and are using it. I don't have them in front of me—

Senator URQUHART: I think 16,000 times is the information I've got.

Mr Weber: Yes, that's correct.

Mr Carroll: Those stats are kept on a three-monthly basis and provided to all the branches.

Senator URQUHART: Those 16,000 are across the country?

Mr Carroll: That's right. We recently were able to put our Victorian colleagues in touch with Apple, and they spent some time at the Apple lab in California developing the next stage of the app, which will now build shift rosters into the app and will work out fatigue levels of members and whether they have had sleep and those kinds of things, to give ready information on the phone that you may be fatigued or whatever.

Senator URQUHART: I don't know whether you can answer this, but is that something that could then identify that a particular shift pattern has worse consequences than another shift pattern? Is that the sort of thing you are aiming for?

Mr Carroll: Yes.

Senator URQUHART: Great. You've just got to make sure that people listen, then, to establish that information.

Mr Carroll: That's it, yes.

Mr Weber: So from the 16,000 downloads that have occurred with the equipt app we've been getting great results and a lot of people using it as well. The same with Dr Kevin Gilmartin when he came out: he went across the whole country, to every single state. The feedback from that—we've received no negative responses at all. Again, we're still at the early stages, so it's awareness and reducing stigma.

Senator URQUHART: So it's anecdotal stuff.

Mr Carroll: In relation to Dr Gilmartin, it was different for all of us, because the way he presents his information can be done through a training session of four hours or it can be done in a theatre hall where he speaks for three hours. In South Australia, my home state, we had on his first visit over 700 members and their families turn up to listen to him. He has been back a number of times to Australia and all the states. He has been able to impart his information to thousands and thousands of families and members across the country, which has been a really good wake-up call for all of us in relation to what we can do as individual state based unions to try and address this issue, because it obviously has, certainly in the last few years, gained a lot more attention than it's had in the past.

ACTING CHAIR: That's open to all police officers, no matter where they are?

Mr Carroll: That's right.

Mr Weber: Yes.

Senator MOLAN: Can I have his name and the book again?

Mr Carroll: Yes. We've got copies of it for you. It's called *Emotional Survival for Law Enforcement.*

Senator URQUHART: That would be fantastic, thank you.

Mr Carroll: We have a number of copies here for you. There's a passage in the book about hypervigilance, which I would encourage you to have a look at, because it really does place—and it's not just for police officers. I think ambulance officers, paramedics, could easily adapt that as well. It really does affect the way that you view the world and the way that you react within it.

Senator URQUHART: Yes, we have heard of this. I think it was Queensland that said they had only one copy, so thank you for that.

ACTING CHAIR: Excellent. Thank you very much.

Mr Burgess: It has a great line which Mark uses. It says, 'We train our police to be sprinters and then enter them in a marathon.'

Senator URQUHART: Yes. Are the equipt app and the information sessions that you get open to all levels of police, from constable up?

Mr Carroll: Yes, they are.

Senator URQUHART: Has there been a good mix of people going to those?

Mr Carroll: Very much so.

Senator URQUHART: From your point of view—and I know this is probably anecdotal because of the recent nature of it—are you getting feedback that there has been some sort of cultural shift? One of the things that we've heard right across this inquiry in all the different states from pretty much all the different first responder agencies is that there's a real cultural problem. The top level seem to be all on board with, 'Let's fix the issues and get people talking about it,' and the bottom level want to talk about it, but there seems to be a stumbling block in between. Part of that has been lack of education and people not understanding how to deal with people. But some of it has been the paramilitary-type style of leadership, if you like. Have you noticed anecdotally or heard any information about whether or not that's made any difference?

Mr Carroll: I think it's a slow burn. It's probably going to take a good decade or more for officers. I think the next generation of officers will probably treat this issue far differently to people of our generation. I've taken the view that we need to make sure that the next cohort that come through don't end up the same way as some of our members across the country who, after 30 or 35 years of service, really hit the wall and can't deal psychologically with the issues that they've had presented to them in their career. Anecdotally, I can tell you of one officer in South Australia who recently, through a court matter, quite openly and honestly talked in his victim impact statement about the impact of a certain incident where a male offender was trying to kill him with a pair of scissors—what that did to him, what it did to his family and how that impacted right across the board. That wouldn't have happened 20 years ago. So, anecdotally, I think there has been some change. Police commissioners

across this country are aware of this issue. They have certainly, through another body called ANZCoPP, targeted this as a really big issue that we need to address.

But you've still got, as you rightly identify, Senator, the middle tier, the claims management processes, causing people not to engage with them. There is a lack of trust, too. People are very fearful of putting their hands up to say that they're psychologically unwell because of what it might do to their career and what it might mean for their operational status. We take the view that it's not a life sentence. If you break your leg, you can get it fixed. If you have some mental ill health, that can be fixed, too. We just need to all be pulling in the right direction and have the same need for the outcome, because we want our members back at work; we don't want them sitting at home.

Senator URQUHART: You said that 20 years ago the sort of stuff that's happening now wouldn't have happened. How good are the different agencies at looking back 20 years and saying, 'We've really damaged that person; what can we do to make it better for them'? Is anything happening around that post retirement?

Mr Carroll: Not coordinated across the country, no. Certainly in Victoria, Commissioner Graham Ashton, the Victorian police association secretary, Wayne Gatt, and the president, John Laird, have recently done the Head to Head Fundraising Walk to raise funds for retired officers and to address for the public what mental ill health in policing is and get people talking about it. But that's probably—

Mr Weber: In New South Wales there is a program called BACKUP for Life which is run by New South Wales Police Legacy and being funded by the New South Wales government. But, again, this is where it comes back to COAG to coordinate. These programs in New South Wales have started being evaluated. If they are best practice, they should roll them out across the other states. BACKUP for Life solely looks after retired police officers or those officers who are just about to retire and makes sure they have a long retirement or that they can find another job if they have to progress somewhere else.

Senator URQUHART: Yes, and sometimes that's support mechanisms for people who have been out of the job for a while and just need some assistance.

Mr Carroll: That's right. There's nothing nationally consistent. In our own state of South Australia, the police association which I run has put together a police support group for serving and retired officers and their families. It meets monthly for people who need to come and talk and get clinical advice. It's convened by a psychologist and other people involved in the mental health space. It's to get people to try to talk about their experiences, try to understand them and try to move on from them. There is a real bitterness and depression with a lot of officers who leave after 30 or 35 years because we haven't addressed the issues for them during their service. So we as unions are all aware of it, but I think the police departments across Australia have got a bit of a way to go to catch up.

Senator URQUHART: Yes, a lot of learning to do. Can you talk around why police officers on workers comp are not able to access similar services if they move from their home jurisdiction. You referred to that in your submission.

Mr Carroll: That's right.

Senator URQUHART: You talked about access to a veterans' health card. Is that the only way to actually fix that problem?

Mr Carroll: I think it's certainly a way that would make things a little bit easier for our retired members—for example, if they move from South Australia to Queensland—depending on their workers compensation claim and how that might have been finalised by the individual jurisdiction. A lot of these claims may have been finalised. Of course, we've all got different legislation for workers compensation. After two years in South Australia, unless you are 30 per cent whole person impaired—and if you've got a psychological injury and are 30 per cent whole person impaired you probably wouldn't be able to fill out the forms—your medical is cut off after two or three years. So it is a pretty harsh system.

Senator URQUHART: It's disgraceful.

Mr Carroll: Yes, I agree it is a disgrace. We railed against it in South Australia for our police officers and we were able to get some extra cover for those who might have been injured as a result of criminal activity within the job or been placed in a dangerous situation. So it is a little bit better than what it is for the rest.

Senator URQUHART: I have some more questions, but I might put them on notice.

Senator PATRICK: I apologise for not hearing your opening statement. I am just trying to understand where you guys fit in the context of the other state based organisations like the AFP Association and so forth.

Mr Carroll: We're the national body. We have our own national constitution. All of our state based and territory based associations are affiliated with the Police Federation of Australia. They're all branches of the Police Federation of Australia. We came into being in 1995 after a contested High Court matter.

Senator PATRICK: If I were a police officer in South Australia and a member of the association there—

Mr Carroll: You'd be a member of the Police Federation of Australia.

Senator URQUHART: Like the ACT system?

Mr Carroll: That's exactly right.

Senator PATRICK: Fantastic. So it's not national per se?

Mr Burgess: Every police officer in Australia that's a member of their respective police association or police union, whether they are in the AFP or in the Northern Territory, Western Australia, Queensland et cetera—

Senator PATRICK: The AFP would cover the ACT police?

Mr Burgess: Yes, that's right, but they're affiliated with the Police Federation of Australia. We represent about 98 per cent of police officers nationally. There's only a very small percentage that aren't members.

Senator PATRICK: I will tell you where I'm going with that. We've had some of the associations turn up and give evidence. Some of them have indicated that the relationship between commissioners and those associations can sometimes not be as good as they should be. I'm just wondering where you guys fit in that regime? Do you have relationships with each of the commissioners? How does it work?

Mr Carroll: Yes, we do. I'm obviously speaking for myself. I'm the President of the Police Association of South Australia, so I deal intimately with the Commissioner of Police in South Australia, Grant Stevens. But, on a national level, we deal with all commissioners as a unified, single, national voice of policing through the Police Federation of Australia.

So, yes, a lot of issues are state or territory based, as far as the jurisdictions go. But, for example, police professionalisation and national wellbeing of our members—for their mental health—are issues that we can speak about with police commissioners through a forum called ANZCoPP, which is the Australia New Zealand Council of Police Professionalisation.

Senator PATRICK: In some sense you've looked at this from a national perspective, suggesting COAG as a mechanism for dealing with things on a national front. This committee has definitely heard that this isn't a coordinated patch—each state seems to be doing things differently, and it's different across ambulance versus police. In some cases that's necessary, but there isn't a shared benefit.

In respect of your organisation and the state based associations—because they have certainly made representations in relation to mental health—I would have thought that was one of those things where you'd say, 'That's a national issue.'

Mr Carroll: Unfortunately, you missed my opening statement. We did talk about that, and our written submission has been developed in consultation with all the branches. They've endorsed our presence here today, but that in no way diminishes the individual testimony from the Queensland Police Union president, Ian Leavers, who we support, and also the submissions from the Australia Federal Police Association and the Queensland Police Union.

I suppose that we're the overarching national body that all of our individual parts are part of and pay funds into. So in that regard, Senator Urquhart's analogy of being like the ACTU is probably the easiest way to explain it.

Senator PATRICK: Oh, sorry—you said 'U'. I thought you said 'police'.

Senator URQUHART: The ACTU.

Senator PATRICK: Sorry—my apologies! One of the things about going to COAG is that it can be a blessing and a curse. Have you considered the curse side of that equation?

Mr Carroll: I mentioned earlier in evidence that we believe now is the right time for it. We think that COAG can provide the coordination and the leadership to—for want of a better term—herd the cats. As Senator Urquhart mentioned, Tasmania will now have presumptive legislation and Victoria—depending on the outcome of their election, I think—will probably have presumptive legislation. It will take years and years for the other states to catch up.

Senator PATRICK: Perhaps I framed that question poorly. I get where you're going with the COAG suggestion. Is that the only pathway you can see? Just in terms of this committee: if it comes up with a recommendation, or at least the observation, that there actually are all these cats out there running in different directions and that they do need to be herded, have you considered any mechanism other than COAG?

Mr Carroll: I think it's probably fair to say that we thought COAG would be the best vehicle for it, because it brings all the states and territories together—all the governments, including the councils. We thought that was the better option. And with you being a national committee, we thought about what kinds of recommendations you could make that would actually have any meaning to the states and territories. That's why we thought COAG would be the best vehicle for it.

Mr Burgess: It probably comes back to your question about the other states. Two of our branches, which made submissions, primarily focused on issues within their jurisdictions. We tried to focus on a national approach to the issue, which, again, as Mark said, has been supported by all our states anyway. We said COAG because if you look at COAG's remit—if you want to talk about what it's supposed to do—it's supposed to manage matters of national significance or matters that need coordinated action by all Australian governments. We'd say that this is a matter which needs some coordinated action.

As Mark said, it's about bringing this together. There are lots of ideas out there—lots of great ideas that have been trailed—and we've heard a lot this morning about the Queensland Ambulance Service et cetera. It's about how you might get everybody in a room to start thinking about this. Not everybody has to do the same, because every individual is different as well in how they're going to respond to individual issues. But it's about how you might try to learn from one another or how sometimes you might use some harmonised approaches to issues et cetera. We couldn't think of any body that had that capacity, other than COAG.

Senator PATRICK: Sure.

Mr Carroll: We're here representing police, but, as far as the committee's work, it is all about emergency services right across the spectrum. That's why it is, to us, very much a national issue.

Senator PATRICK: I like the recommendation. I am just wondering whether, in forming that recommendation, that was the second choice—

Mr Carroll: We've gone for the rolled gold.

Senator MOLAN: Part of the problem that I assume many police face is exacerbated by the amount of time they spend on duty. In the manning that you see in the states within the jurisdictions, is this an aspect of manning?

Mr Carroll: Resourcing.

Senator MOLAN: When the state funds the manning level of police, are certain levels of equipt-type application applied by them or not? The less time I imagine you spend on a shift—

Mr Carroll: We don't, across the country, really have any minimum staffing levels for any shift, which is something that, as individual unions and associations, we've been arguing for for years. We can actually convince state governments and territory governments to recruit more officers to increase the size of the force, but we don't have any real control over where the police commissioner of the day may put those resources. We have an old saying that there's nothing new under the sun in policing. One minute they centralise, then they decentralise; they specialise and they generalise. And it seems to be going around and around, and if you stay around long enough you'll see the whole thing play out. So we, as organisations, are obviously very keen to make sure that the front line of policing, the general duties of policing, have sufficient staff, because that's where a lot of our issues—when you have not enough people to do the job—start to create that anxiety, that depression and what not. That's always an issue for us. In relation to the equipt app, I think you asked: how does that work? Obviously, the next tranche of rollout will build around the shift rostering type of thing, but it won't take into account the staffing level.

Senator MOLAN: Has your federation specifically taken it to commissioners and said that there should be minimum staffing and you've been knocked back?

Mr Carroll: That's something that police commissioners, because of their discretion, don't particularly like to lock down as to what any particular staffing would be at any given time. I can understand their argument—it's quite a dynamic workplace, and sometimes when you say 'minimum' that becomes the minimum and the maximum. So you've got to be careful what you wish for too. But certainly there should be enough data around in relation to the work of any particular team or station around Australia in different parts as to the kinds of responses that you're going to have to get, the kinds of calls you're going to get, the taskings you're going to get. I'm sure police commissioners would argue that they do look at all of that when they assign their resources. But our members, for all of our jurisdictions, are constantly saying there are not enough people on the front line to do the job.

Mr Weber: There are first response policing agreements in New South Wales, but, again, that's an agreement with the local area commander and then the individual branches of the police association or unions. Also, in the

Western world, we have some of the lowest police-to-population ratios across the board, and that's why there has been a real push for increasing police numbers. You'd find all jurisdictions are requesting that. Victoria's just got over 3,000 officers over the next term of government, Queensland's got over 500 and New South Wales is asking for 2,500 just to deal with the ongoing issues of crime. Mark Burgess before helped facilitate this, but there was a flexible working arrangement survey that we did across Australia and New South Wales, and we had over 11,000 officers respond. That's about 16.5 per cent. The most frequent identifying factor for stress in the workplace was the lack of support of management, but then workload and resourcing issues are rated as a significant factor by about 40 per cent of police. It's that constant workload, constant stress that you're talking about and not having adequate resources that actually deal with those jobs, day in day out, We've talked about this many times before: the bucket just gets full. It's that slow drip process. The bucket's full and then all of a sudden we have the officers that are putting their hand up and they're injured and off work.

Senator MOLAN: Thank you for that.

ACTING CHAIR: We are going to have to leave it there and move on to the Australian Federal Police. Thank you very much for your appearance here today. We really do appreciate it. And thank you very much for your reading material.

Mr Carroll: Thank you. If there are any follow-up questions, we will respond.

BIRD, Ms Sue, Chief Operating Officer, Australian Federal Police

COLVIN, Commissioner Andrew, APM, OAM, Australian Federal Police

CROZIER, Mr Peter, Commander and Acting National Manager of People, Safety and Security, Australian Federal Police

SANDERS, Dr Katrina, Chief Medical Officer, Australian Federal Police

[14:45]

ACTING CHAIR: Welcome. Thank you very much for being here today. I understand that information on parliamentary privilege and the protection of witnesses and evidence has been provided to you. Commissioner Colvin, do you wish to make some opening remarks?

Mr Colvin: Thank you for the opportunity to appear this afternoon. I have thought a lot about the issues that this committee is considering and grappled with what you need to consider. I have seen some of the evidence presented to you and it is consistent with those stories that I have heard firsthand as well—and it is confronting. This is as complex as any issue currently being faced by policing, and the work of your committee is very important. I am afraid to say that, while many solutions will be presented, there is no simple solution that will address all aspects of the challenge. You have heard evidence about stigmas, about the need for legislation to be reformed, about research, about former police suffering and about current police suffering. I know that I speak on behalf of former AFP commissioners as well when I say that the health and wellbeing of our members has always been at the forefront of our minds but we have not always fully understood what this has meant. What is positive is the fact that a national dialogue has begun. The very existence of your committee is a step forward towards proper recognition of the role and struggles of police in our society.

The last two weeks have been particularly hard for the AFP. I'm sure you have seen the reports of a death of an officer within our headquarters just down the road here in Canberra. You'll also have seen the reports that this brings to three the number of AFP members who have taken their lives inside AFP premises in recent years—and I cannot begin to tell the committee the impact this has had on my workforce. It brings into stark relief the issues of mental health and the need for us to consider what more can be done to safeguard the wellbeing of police and other first responders. But, equally, we should not rush to conclusion or make assumptions about those deaths or what factors may have been at play in those members' minds.

Police are overrepresented in statistics on work related mental health injury. In fact, early research indicates that policing is the occupation at the highest risk of mental health injury. We have a privileged role in society but, as you've heard, it comes at a cost. And the AFP is not immune. I am acutely aware that we can do better in our mental health support services. This has been a significant priority for me as commissioner. Since I was appointed in 2013, the AFP has taken a great number of steps to proactively address the mental health and wellbeing of our members, both sworn and unsworn. In late 2016, we appointed a new chief medical officer, Dr Katrina Sanders, who is here with me today. Dr Sanders appointment was coupled with the restructure of our wellbeing services, improving the way my officers can access the range of holistic health resources. She has led the effort to improve our performance in this area.

There are more options available to our members today than ever before. We continue to take great steps forward to address concerns of members and address the attitudes and cultures that have made this such a difficult issue for boys. But, equally, we know that we must continue to do more. We engaged Phoenix Australia, off our own bat, to conduct an unrestricted review of the health support services within the AFP. The review was self-initiated and we knew we needed an unbiased view from leaders in the field on how we can better support our members. We have also worked with the ANAO on their report, as well as our work with beyondblue and the Australia21 report *When helping Hurts*. We have not been backward in coming forward on this issue.

We have accepted all recommendations made in the Phoenix and ANAO reports and have incorporated them into the AFP health and wellbeing strategy released earlier this year. The strategy sets the expectations for health in the workplace and, importantly, it establishes a clear foundation for our ongoing efforts to improve organisational wellbeing. While there is often a focus on the services available to police, what satisfies me the most is that this health and wellbeing strategy is based on prevention and education. A survivor of mental health challenges, someone who is a prominent sportsperson and well known in Australia, once said to Australian and New Zealand commissioners collectively that we need to invest in building a fence at the top of the cliff and not just focus on the ambulance at the bottom of the cliff. It is a confronting thought but it is incredibly true.

As part of our commitment to health and wellbeing, all AFP staff have access to support systems, including a 24-hour Employee Assistance Program and an internal team of psychologists, nurses, chaplains and social

workers. These numbers have grown and continue to grow. Thanks to our support systems, serving members who have experienced mental health injuries, including PTSD, have received the support they need to return to health, return to work and continue their career pathways with the AFP. We have also taken important steps and action to address the AFP's culture more broadly. If we treat each other with respect, and value inclusion and a safe workplace, then we are far more likely to identify someone who may be struggling and help them to take the necessary steps.

But there is more to be done and I'm committed to making real, tangible change to address the continuing mental health of my members, both when they are serving and when they leave the Police Force. I speak often of the passion and commitment of AFP officers. I see that every time I come to work. But what about those members when they reach the end of the career? Police can, and do, become lost and depressed at the thought of leaving the job that they love, a job that is so integral to our sense of identity, a job that for many of us becomes a lifelong enterprise. Mental health injuries are not always immediately apparent and can arise some time after the exposure to trauma or after a person may have left the workforce and its support structures.

A lot has been said lately about the support offered to our defence veterans. This is a welcome intervention and something we should applaud. But, likewise, I hope the same discussion will include both serving and former police and, for that matter, first responders of all types. Police officers need acknowledgement that the job they have volunteered to do is dangerous. The injury, the trauma, may not always be immediately apparent but the cost is no less tangible and real. I have spoken to many officers, both serving and former, who have struggled with the impacts of their service. The common refrain from them is that they felt they had to justify and prove themselves time and time again. Particularly when dealing with external agencies and compensation providers, they say the process felt designed to disbelieve them rather than support them—the process put in place to help them get better often pushed them further to the margins.

In reflecting on how we can better serve those who have served the community, I look to the model of care and support offered to military veterans. This includes a specialist multidisciplinary advisory board and a non-liability healthcare scheme for a range of health conditions, including conditions related to mental health. I look at our colleagues overseas and now here in Australia who, as we have just heard, have moved to presumptive legislation or the provisional acceptance of mental injury claims. These are simple yet effective steps. We can't do this alone. This is a complex issue and it needs a sophisticated and layered response. To get the best outcome on mental health for first responders, our approach needs to be cross-jurisdictional and multidisciplinary.

Unlike the military, policing is not one homogenous entity in Australia. This will come with its own complexities. I note the constitutional limitations on the Commonwealth, but I believe it is possible and it is vitally important. The Commonwealth can and should take a lead role. We need to understand this as a nation and take concrete steps. The AFP submission provides you with ideas to begin the process, as have other submissions that I have seen. Personally, I believe that the first step is to ensure that the work of this committee does not end when you submit your report. A coordinated national strategy is vital and this could begin with the creation of an enduring panel of experts or eminent persons—something similar to the Defence national advisory committee—with clear responsibilities and ministerial accountabilities to ensure that we continue to move in the right direction as a nation.

ACTING CHAIR: Thank you, Commissioner Colvin. Dr Sanders, where are we in our understanding—particularly from a police point of view but also more broadly—as to the best path for first responders? Is it about the identification of people who need assistance, hopefully before it actually becomes a problem? Is it about the treatment of people with a problem—early intervention? Do we have a good handle on how to approach these things, and are we effective when we do identify people who need assistance?

Dr Sanders: Great question. International evidence suggests to us that the single greatest barrier for first responders in terms of mental health is education and awareness. If I reflect a little on the AFP, that might assist in answering your questions. We know that health in first responders is complex and multifaceted. We know that the best psychological prevention strategies, the best doctors and the best social workers are not necessarily going to combat mental health issues in first responders. We need a holistic approach. We know that it means psychological support, physical support and organisational initiatives. But also, critically, in first responders, as I am sure you are aware, families are often the first to notice the deterioration in health. And so, at the AFP, we are trying to adopt a model that approaches all these key concepts.

So, in answer to your question, we know that it is about a complex interplay of health. We know that we must adopt a holistic approach. But in terms of research, particularly in Australia, and in terms of effective intervention, particularly in Australia, that evidence base is not quite there. We know some programs that work anecdotally in different industries and different organisations, and we tend to adopt them. But that true evidence

base doesn't really exist at this point. In terms of effective treatment, what we do know is that what is effective treatment for you is different for someone else, particularly in first responders. And so, at the AFP, we have tried to adopt a suite of treatment interventions so that we can tailor that to be most effective in the individual case.

ACTING CHAIR: What concerns me, from listening to the evidence, is that not that long ago the standard procedure after a particular traumatic incident was a debrief. We have also heard that the consensus now seems to be that that is actually counterproductive for people's long-term mental wellbeing. How confident can we be that the building blocks we are putting in place now are actually the best ones we have? Is the evidence base there to know that we are at least not doing any harm, or do we need more evidence?

Dr Sanders: Certainly the evidence is that we are not doing any harm, and that is largely from our international colleagues. But the longevity of that is impossible to predict, and that is because a lot of these initiatives are new. You are right about debriefing. As a method of debriefing, we used to get people into a room together and everyone would describe what they saw. But we now know that that exposes other people to trauma or to different memories that they didn't actually have. So now it is more about psycho-education—we talk about what you may feel or experience in the coming 48 to 72 hours. We know that that has great evidence around it now. So we don't believe the interventions that we have put in place are harmful; their longevity and effectiveness into the future remains to be seen.

Senator PATRICK: The AFP have been making a fair amount of effort in this space over the last couple of years. You would be aware that I was an adviser to Senator Xenophon when he was raising some of these issues. You have gone through Broderick, Phoenix and the ANAO. Out of that, there have been a number of changes in terms of training and support services, medical services and so forth. Do you have a measure of the cost associated with that? I think you guys are probably more advanced than some of the other police forces. I want to get a feel for the cost that has been involved with this particular area so that we can get a metric as to what it is likely to cost in other jurisdictions.

Ms Bird: I have got the employee figures. It would be a good exercise—and I haven't done it yet—to group up all the costs associated with the work that we have done. I certainly have employee costs in terms of the building of the teams in accordance with the Phoenix recommendations. In terms of one holistic figure for everything and every man-hour of effort that goes into this, I haven't got that together. What I can give you is that in the last financial year—that is, 2017-18—we spent about $8.3 million on employee costs and $17.1 million on supplier funds to support health related outcomes. We expect to spend similar this year or build that slightly in accordance with the Phoenix ramp-up.

Senator PATRICK: How does that compare to a couple of years ago before Broderick, for example?

Ms Bird: I'd probably have to take that on notice; I haven't got that comparison going backwards.

Senator PATRICK: You see where I'm going as a useful case study of what it is that you're doing?

Ms Bird: Yes.

Senator PATRICK: We heard evidence today from Comcare and some of the insurance companies of how premiums are tied to previous claims and obviously risk and so forth. Are you able to give us some indication as to the premiums that the AFP have been paying in respect of Comcare? The evidence given today was that the premiums are still going up, and there's some latency perhaps involved in that. Have you been monitoring that as well and looking at, as you're spending more money, whether it's helping out with premiums?

Ms Bird: The first thing I'd say—and Katrina may well wish to add to this—is that our Comcare premiums are increasing. I'm sure others are, and Comcare could give you that information. The thing about Comcare premiums is, even if we sunk a huge amount of effort in today, it's going to take a while to reflect on premiums. Premiums are calculated over a period of time, so what we'd probably see in this year's and next year's premiums reflects behaviour and injuries over the past couple of years as well as this year—sorry; that sounds a bit inexact; I'm sure we can get you an exact answer on that. As we increase our efforts in this space, we would expect to see the Comcare premium coming back down. It certainly has gone up over the years. That's an indicator for us—and it's obviously not good for the AFP—but it's one of many reasons, not the main reason, that we would want to do the work that we're doing on mental health.

Mr Colvin: Could I just add to that. Just coming back to your question before: the figure that the chief operating officer gave you is around our efforts in organisational health. It doesn't include our broader efforts around culture and the Broderick report. That's a broader question, and we'll attempt to bring that together. There are a lot of opportunity costs as well as hard and fast costs.

The other thing, though, on the premiums is: yes, we are making up lost ground, if you like, on the way that perhaps we have managed this in the past in policing, and our rate of members coming forward to say that they

need help, or that they are struggling, is increasing. Now, that's a good and a bad thing. We are slowly reducing the stigmas that make it okay to come forward and present as wanting help. In the past we wouldn't have had that, so I will expect our premiums are going to go up for some time.

Senator PATRICK: I'm not in any way criticising—

Mr Colvin: No, I know.

Senator PATRICK: I'm essentially saying—and maybe you could comment on this—that the AFP in some sense is leading the way and doing a lot more than perhaps other police forces. Therefore it's a good case study to look at how much it costs, to look at the results not just from a financial perspective—I was going to go to you, Dr Sanders—and a cost metric. You've talked about more people coming forward and reporting. What metric do you use to establish that you're getting better in this space? Do you have a metric? Do you have something where you say, 'This is how we know we're getting better. Sure, we're getting more reports. That's because the stigma is going'? How do you measure that?

Mr Colvin: Our metrics would be around number of reports and the length of time before we can rehabilitate and bring people back into the workplace. There are lots of time line numbers that we can start to report on as we get better and understand this better.

Senator PATRICK: When people are reporting, are you able to say whether you're catching them earlier because of the lack of stigma?

Dr Sanders: Anecdotally, we can just from what they tell us, but we wouldn't be capturing any data around that. That's largely because there's a whole network of ways to capture people, and we're trying to encourage colleagues and supervisors to be the first point of catchment, so we wouldn't be able to get that data.

Senator PATRICK: And I guess it's difficult to measure culture change as well.

Senator URQUHART: We had the ANAO in earlier. Can you take us through your progress in implementing the recommendations from that report?

Ms Bird: Yes. Did you want to go through each recommendation?

Senator URQUHART: Yes, please.

Ms Bird: Recommendation 1 was about the development of a comprehensive organisational health strategy. That health strategy has been developed. It's in place.

Senator URQUHART: It's on the website.

Ms Bird: It's on the website. You've got a copy of it?

Senator URQUHART: I have now, yes.

Ms Bird: It's the strategic document by which we're developing and continuing to develop the sorts of policies and processes that sit behind that in Dr Sanders's space, and that's an ongoing process, I suppose. Did you have any other specific questions about the strategy before I move on to another recommendation?

Senator URQUHART: No. Except that when I questioned the ANAO they said that it had been in play since 2016. This is 2018-23, is that the same document that was in play in 2016?

Ms Bird: Correct me if I'm wrong, Katrina, but in 2016 we contracted Phoenix to do this piece of work, so there was a bit of a suspension, if you like. We'd already started down this path, but we thought it was extremely sensible to have Phoenix input into the final strategy. While the strategy had been in play, it was largely because of the single and unique piece of work that Phoenix was doing, which from memory took about 12 months. While the final strategy is dated 2018 that's because of the Phoenix input to it.

Senator URQUHART: In terms of rolling this out amongst the workforce, has that happened? What has been the process with this document now?

Ms Bird: Yes. The strategy was formally launched. Katrina, did you want to talk more about how we refer to it day to day?

Dr Sanders: Yes. The strategy was formally launched in May this year, and since then one of our primary efforts has been promotion and resourcing in our regional centres. That's through the engagement of a number of mental health professionals, including psychologists and social workers, but also the education of the Welfare Officer Network that we have. The strategy forms part of our communication tool with the wider organisation. Events such as R U OK? Day all relate to the strategy and the initiatives we're rolling out.

Senator URQUHART: I notice that there are a number of factors in the health protection action plan. One talks about leadership, another talks about education and another talks about culture. Culture has been a really big

theme throughout this entire inquiry. Continually people have said, 'We need to change the culture of the workforce.' What I've generally gleaned from the evidence that we've received is that people at the top of the chain of command have said: 'Yes, the culture's great. We need to respect people. We need to make sure that they can speak up if they have an issue.' People at the bottom want to do it, but there's a fear of reprisal in terms of their job, their career aspirations—a whole range of things—or just what will happen to them if they do speak up, and that seems to be at middle management. I keep having to say this, I'm not actually having a real go at middle management. I'm actually saying sometimes they're the wrong people—I will say that. But quite often they're not given the tools, the training and the expertise to be able to deal with issues about how to implement things. Can you talk me through what you're doing to change that culture at that level?

Mr Colvin: Yes. I might kick-off and the doc and Sue will have more to say on that as well. I absolutely agree with what you're saying. And that's not a reflection of my middle management. It's a reflection of the fact that I've been in the organisation 29 years, and for 26 of those years this was not something that was an issue for me to deal with. We are trying to change attitudes and cultures across the organisation and make this important. I heard the PFA quite rightly talking about the pressures and stresses on police to get the job done, and this is something else I'm asking them to do. I'm asking them to do it and to prioritise it, because the health and wellbeing of our people leads to all sorts of capacity and capability outcomes for us as well but that takes time to change.

So, I do agree that, certainly speaking from an AFP perspective, large portions of my organisation are waiting and want change. I can say it from the rooftop as many times as I physically can, but, until I start to get that cascading and trickling down through the organisation, which will take time, I won't get the traction that I need. We are working very hard on our leadership development at all levels of the organisation. That's from constable and recruit up, frankly. Leadership in policing is sometimes seen as the thing that the person above you should be exercising. It's something we should all be exercising. We are inculcating health and wellbeing strategy discussions into our normal, everyday dialogue. We are educating my SES and senior leadership team about why this is important. But that's going to take a long time, Senator. It is going to take time.

Senator URQUHART: I understand that there's still a lot of research going on in this area and there's a lot of work to be done. We're talking, sometimes, about generational change. I think we've heard from the police association previously that it could be the next generation of recruits that is very different, and we sort of have to live with what we've got at the moment. But, while people are being injured and damaged and dying, there must be something that can quickly address some of those issues so that we halt that process.

Mr Colvin: I agree that we can't wait for generational change, because people will continue to be injured in the meantime. I don't know that there's something that we can do quickly other than what we are doing and what we are investing a lot of effort in now, which is to educate all levels of the AFP, particularly those frontline managers, who will see this long before the doc or I see a problem emerging with an officer. We are doing that. I'm not sure whether the doc or Sue want to add anything.

Ms Bird: Did you want to talk about the training?

Dr Sanders: I've got a couple of comments, Senator. Unlike Defence, I would say first responders don't necessarily have a concept of the culture of health. In Defence, it is right in their face: must be healthy to deploy; must be fit all the time. But, because first responders do this job every day, it is not in their psyche at all. That's the first battle I have. The other battle I find—this is particularly regarding police—is that they are the people that people go to for help. They're the ones that do the investigating. They're the ones that the public turn to. It is inculcated in their training very early on to certainly hide, or at least suppress, emotion. That skill, developed over decades, is very challenging and arguably impossible to break down.

Really easy practical steps that we're taking at the moment to make a difference, particularly around the middle management area, are simple things like, 'Use this language; don't use this language.' We send those types of emails around regularly. We have a series of videos of senior members and other members in the organisation talking about their own health experiences to try to normalise health and break down stigma, as well as a huge education campaign we have going at the moment. They're just a couple of practical steps that we're taking at the moment.

Senator URQUHART: Okay. Can I get you to quickly run through the other five recommendations? I have some other questions apart from those on the recommendations.

Ms Bird: We were up to?

Senator URQUHART: We only did the first one.

Ms Bird: Recommendation 2 was to define and report on mental health risks. We've been increasing our efforts in that regard. Katrina, I think you've already touched on some of that. Did you want to elaborate on that?

Senator URQUHART: I guess what I'm also interested in is your progress in implementing, and maybe a time frame for when these things will be implemented. Do you have a time frame for that?

Ms Bird: It will depend on the recommendation, to be honest. Some of the recommendations were fairly quick and easy to implement. For example, with recommendation 3, mental health first aid training, we have already implemented that and that has been rolled out. We've also implemented an early intervention program, which is also happening right now. The recommendations which talk about improvement in ICT systems, obviously, are going to take a longer time.

Senator URQUHART: I think the ANAO touched on that, that some of the recommendations would involve some IT changes et cetera, so they might take a bit longer. I think their suggestions were that things like the mandatory health training would be an urgent thing—which you've done?

Ms Bird: We have already acknowledged that.

Senator URQUHART: The third one was to develop formal processes. Their suggestion was that that would be easily implemented.

Ms Bird: Dr Sanders can talk more about how we manage those processes around screening and so on.

Dr Sanders: All of the ANAO recommendations are underway, Senator. All of them have been phased in the health and wellbeing strategy to at least commence implementation within the next three years. Some of them are easy to achieve and some of them overlap. Certainly, for example, psychological screening for high-risk roles is well underway.

Senator URQUHART: Look, I'm happy if you can give me some more detail around those six recommendations on notice—where they're at and the time frame that you're looking at to implement them.

Mr Colvin: We'll give you some detail, Senator.

Senator URQUHART: That would be great. In your submission, you note that there's little evidence that exists on the frequency of mental health issues in police. Again, we don't know exactly, because of that. Are you aware of the work by the Black Dog Institute at the University of New South Wales with Fire and Rescue NSW? Are you involved in any of that or have you taken any initiatives out of that?

Dr Sanders: We're not involved formally with it at all. We do have informal links with the Black Dog Institute; not with the university. I'm aware of some of the initiatives that they're rolling out, yes.

Senator URQUHART: We had them at the Sydney hearing, and it seems like they're starting to do some really good work around the fire departments, with middle management training and that sort of stuff—early days, but still good.

Dr Sanders: The great four-hour program that they've rolled out.

Senator URQUHART: Do you have any additional information on how the AFP might use their beyondblue results to improve the provision of mental health services for officers? I think that report's due out towards the end of this month. Any idea of how you guys might use that report to actually assist in the mental health of officers?

Mr Colvin: I might answer that to start with. The police commissioners will stand up together and launch that report a little later this month. To the extent that there is anything new in there that helps us, that we haven't already, through Phoenix, ANAO or our work with—I know you spoke to Mick Palmer this morning. Absolutely, we will continue to look for whatever good ideas there are. Categorically, I can say that the answer is yes, but what we need to do is understand whether there is anything new in there that we're not already trying to do.

Senator URQUHART: Great. You talked about presumptive legislation. You would be aware of Victoria proposing to introduce it and that Tasmania has basically introduced it. How do you think that will change—I think your words were, 'Simple but effective.'

Mr Colvin: From my perspective, having sat and spoken to a lot of people who have struggled with their service, I want to do anything that reduces the burden placed on them to prove why they are as they are. The most gut-wrenching thing that I feel powerless to stop is the sense that people are having to go through the trauma time and time again to get help. Now, we are trying inside the AFP to reduce that and strip that away, and I know that other agencies are as well. I'm not casting aspersions on other agencies here. If they simply feel that they are being believed and they are being trusted, and the legislation supports them to be believed and trusted, I think we go a long way towards reducing that stigma.

Senator URQUHART: Comcare is your provider?

Mr Colvin: Yes.

Senator URQUHART: Have you had discussions with Comcare around that?

Mr Colvin: We have, absolutely.

Senator URQUHART: How successful have they been?

Mr Colvin: I will ask the doc to comment; she has been working with them directly. I've recently written to the secretary of the department to say I want to formally start the process of moving down a legislative path, but that's on the back of a lot of discussions that we've already had. Katrina will be able to give you more detail.

Dr Sanders: Certainly as a stepping stone to that we've partnered with Comcare in improving the acceptance for post-traumatic stress disorder to reduce the time frame and also the need to go through an independent medical examination. That's the first step in presumptive diagnosis with Comcare. The important thing about presumptive legislation is that we know that it will reduce stigma and, importantly, it will improve access to robust treatment pathways, and then people get timely access to treatment and the right treatment, which improves health outcomes.

Senator URQUHART: Can you talk to me about return to work and how that's managed through the AFP, and also post-retirement support—once someone has retired? Now, that might be their choice of retirement or it might be forced retirement because of an illness or an injury. How do you support officers in that capacity?

Mr Colvin: Just so I'm clear, Senator, and the doc will be able to give you the material, you're not talking about someone who has retired for reasons unrelated to mental injury or any other—

Senator URQUHART: No, particularly more around retirement due to injury, mental illness or whatever.

Dr Sanders: I can talk you through our return-to-work processes. We have an internal and external method of supporting individuals in returning to work. First of all, internally, we engage with the supervisor, and a case manager is allocated. That's in both compensation and non-compensation matters. Externally, we engage the services of a rehabilitation consultant to assist us in negotiation and discussion between the workplace and private treaters as well. A lot of the time we get involved—

Senator URQUHART: Are they skilled in police work?

Dr Sanders: A number of them are. We do that internally, through AFP, through a number of presentations and regular meetings with them. That's largely how we manage our return to work. We do need to be guided by private practitioners, and often psychologists, nurses and myself are involved in conversations with those practitioners, to really assist the members returning to work. In terms of retired members, and particularly those who are medically retired, I think it's fair to say we've got a lot of work to do towards improving our transition processes. That was highlighted in Phoenix and ANAO, and we are working towards that. In the last 12 months, we've recognised that our retired members need more. We've opened up our employee assistance provider to provide support to all former members. We have a triage system with—

Senator URQUHART: Does that have a time frame linked to it?

Dr Sanders: No.

Senator URQUHART: So, any previous AFP person can knock on your door and say, 'I want to use this service'?

Dr Sanders: Absolutely. They can use our internal triage system, which has a nurse, a social worker and a workers compensation specialist, but we've also broadened our welfare officer network to include retired members as well.

Senator URQUHART: Great.

ACTING CHAIR: We'll need to leave it there. If you want to add to that, please feel free to forward any information through to the secretariat. Otherwise, thank you sincerely for your time today.

ANDERSON, Ms Jody, Group Manager, Work Health and Safety Policy Group, Department of Jobs and Small Business

BAXTER, Ms Michelle, Chief Executive Officer, Safe Work Australia

BREEN, Mr Adrian, Branch Manager, Work Health and Safety Policy Branch, Department of Jobs and Small Business

CAINS, Mr David, Branch Manager, Workers' Compensation Policy Branch, Department of Jobs and Small Business

GARRED, Mr Kris, Director, Evidence, Safe Work Australia

JOHNSTON, Ms Amanda, Acting Deputy Chief Executive Officer, Safe Work Australia

RAVEN, Ms Anthea, Acting Branch Manager, Strategic Policy Branch, Safe Work Australia

TAYLOR, Ms Jennifer, Chief Executive Officer, Comcare

[15:29]

ACTING CHAIR: I welcome representatives from the Department of Jobs and Small Business and from Safe Work Australia. I understand information on parliamentary privilege and the protection of witnesses and evidence has been provided to you. I remind senators the Senate has resolved that an officer of a department of the Commonwealth or of a state shall not be asked to give opinions on matters of policy and shall be given reasonable opportunity to refer questions asked of the officer to superior officers or to a minister. This resolution prohibits only questions asking for opinions on matters of policy and does not preclude questions asking for explanations of policies or factual questions about when and how policies were adopted. Officers of the department are reminded that any claim that it would be contrary to the public interest to answer a question must follow the relevant procedural order and be accompanied by a statement setting out the basis for the claim.

Ms Anderson: I will make a short opening statement. The department has broad responsibility for work health and safety law and policy in the Commonwealth jurisdiction, which involves the application of model work health and safety laws. The model WHS laws have been in place since 2012 and specifically include management of risks to psychological health. The WHS laws require risks to be managed so far as is reasonably practical. There are always more things that can be done to protect all workers and particularly first responders. However, I would note, as other witnesses have, that this is a complex area where our understanding of the hazards and risks and what can be practically be done to manage them is evolving.

There has been some important work done in this area in recent times, including by Safe Work Australia, Comcare and state and territory regulators. This work is aiming to make the management of psychological risk simpler so any organisation can clearly see the steps they need to take. The psychological risks need to be identified at an organisational level and control measures implemented before an emergency situation occurs. Good work design and consultation with workers are essential to identifying higher order control measures and implementing them to best effect. If workers are injured, it is important that they are supported and given assistance to remain in or return to safe and sustainable work. It is widely accepted that returning to good work that is safe quickly benefits both employees and employers where it is possible.

As outlined in our submission, the department also has policy responsibility for the Safety, Rehabilitation and Compensation Act, the SRC Act, which covers first responders in the Commonwealth and in the ACT government. Defence personnel are covered under military-specific compensation schemes. The SRC Act provides for rehabilitation and compensation for employees who suffer a work-related injury or disease, including psychological injuries. Comcare, as you heard this morning, works with employees and employers to minimise the impact of harm in the workplace, improve recovery at work and return to work, and promote the health benefits of work through good work design. That's it from me.

Ms Baxter: Safe Work Australia welcomes the opportunity to appear before the committee today and we'll be happy to answer any questions the committee may have. Safe Work Australia works to achieve healthier, safer and more productive workplaces, and the way we do this is we lead the development of national policy and strategies to improve work health and safety and workers compensation arrangements across Australia. However, Safe Work Australia does not regulate work health or safety or workers compensation laws and we have no role in relation to enforcement or compliance. These roles sit with the jurisdictions—the states and territories—and the Commonwealth as a jurisdiction.

Safe Work Australia is an inclusive tripartite body comprised of 15 members. Each of the jurisdictions in Australia is represented, as well as representatives from employer groups and representatives from employee groups. As noted in our submission to this inquiry, one of Safe Work Australia's key functions is the maintenance of the model work health and safety laws. The model laws are of themselves not legally binding, but have been implemented in every jurisdiction in Australia, except for Victoria and Western Australia. The aim of the model laws is to provide all workers in Australia with the same standard of health and safety protection, regardless of the work they do or where they work. The laws are robust, they are outcomes based and they allow organisations to tailor their approach to safety to suit their circumstances.

The primary duties in the model work health and safety laws apply to mental health in the same manner as they do to physical health. Relevantly, that duty is to ensure the health and safety, including the mental health, of workers as far as is reasonably practicable. Psychological health and safety is a priority for Safe Work Australia and, as such, mental health conditions are identified as a priority condition in the Australian Work Health and Safety Strategy 2012-22. Safe Work Australia has produced a range of guidance materials and resources to assist workplaces and persons conducting businesses and undertakings to prevent and minimise harm to psychological health and safety. Most recently, we published the guide *Work-related psychological health and safety*, which provides guidance on identifying and controlling risks, intervening early and supporting recovery and return to good work.

Safe Work Australia is also currently leading the development of a national return to work strategy. Psychological health, workplace culture and early intervention have emerged as strong themes through initial consultation. Safe Work Australia has also undertaken, commissioned and funded a body of research on psychological health and safety in the workplace. This research draws on a range of information and data sources, including national data sets that are compiled by Safe Work Australia. As noted in our submission, this data tells us that first responders experience higher rates of serious claims due to psychological injury resulting from stress or exposure to traumatic events. We also know that workers with these types of injuries typically take more time off work, receive higher claim payments and are less likely to return to work at all.

Safe Work Australia is committed to continuing to work with jurisdictions, our social partners and other stakeholders to improve the health and safety of all Australian workers, including our first responders. And we do acknowledge that there are very serious and unique risks faced by these workers in the very important work they do. Thank you.

ACTING CHAIR: Thank you very much for that. Ms Baxter, there's a question I've been asking a number of witnesses. The state of the research, particularly in the preparatory or prevention space: do we have any good research? Are there any international leads we can look at for jurisdictions that are doing it better than us, if anyone?

Ms Baxter: In relation to mental health?

ACTING CHAIR: Particularly in relation to mental health.

Ms Baxter: Okay. Yes, we have done quite a bit of work in relation to mental health in the workplace health and safety space. I might ask my colleagues to provide you with greater detail in relation to that work and any of the leads that we've obtained looking internationally as well.

ACTING CHAIR: You've just put together a framework—is that correct?

Ms Baxter: A guide; that's right, yes.

Ms Raven: There is strong evidence that intervening early is likely to lead to better outcomes, but how you actually do that in practice is challenging, and the evidence in that space, that practical application, is still evolving, as other witnesses have noticed. There are certainly factors that there is strong evidence to support going toward creating healthier and safer workplaces to prevent psychological injuries. There are things that are noted in our submission and in *Psychosocial safety climate and better productivity in Australian workplaces* report, which has a look at poor psychosocial safety climates and the impacts on organisations. There has also been research done through the *Australian workplace barometer*, and that particular study cited a study of Australian police officers that found that high levels of psychological safety climate enables other resources to be effective in moderating psychological risks.

There's also work that has been undertaken to look at the relationship between work characteristics, wellbeing, depression and workplace bullying. That evidence has shown the impact of bullying could be minimised by support from colleagues and managers, as well as fair reward for effort. Our guide to psychological health and safety that we've recently released pulls together a lot of the available evidence and looks at the common

psychosocial hazards and factors that increase the risk of work related stress, and then puts forward ways that organisations can manage those factors and mitigate or control for those risks.

ACTING CHAIR: Who is the prospective audience for the guide? Is it employer organisations, is it individual employers? In the case of what we're looking at, is it the police associations, the police departments? Who is the audience for the guide?

Ms Raven: The primary audience of the guide is PCBUs that have duties under work health and safety laws, but also employers with responsibilities under workers compensation laws. This guidance is the first to actually put work health and safety and workers compensation together in end-to-end guidance. Having said that, I think there is benefit in the guide being adopted by associations or organisations that also influence workplaces and workplace practices.

ACTING CHAIR: This is probably an unfair question, but have you had a chance to listen to any of the evidence given either at earlier hearings or today? How do you think the emergency services are going? Do you think they're already some way towards meeting what the guide would indicate? Have they got a way to go? Are there learnings in the guide for them, or do you think that most of the first responder organisations are already at least part way along that path?

Ms Baxter: The guide really sets out to educate employers and PCBUs in terms of their obligations under the model work health and safety laws. To the degree that it can assist first responder organisations and agencies, I think it would be useful for them to have a look. I'd be surprised if a number of them haven't already. We've been receiving quite a lot of feedback from stakeholders in relation to the guide, in particular about the usefulness of it. That's something we hear quite a bit from stakeholders—that is, the material that is put out can be overly bureaucratic in language and not helpful and not understandable. We've really strived, in developing this guidance material, to make it something that an operator of a small business could pick up, or an operator of a large business. It's really meant to be practical guidance for how to comply with your duties under work health and safety laws.

We haven't heard a lot of the evidence. We were here for the AFP a short while ago. It sounds like they've got plenty of material that they're working with, and they sound as if they're quite a way along in terms of what they're doing, but I don't have any specific or intimate knowledge of their situation, I'm sorry.

ACTING CHAIR: Fair enough.

Senator URQUHART: I have some questions for both groups. I might start with the department first. Your submission notes that workers need access to medical support before a claim is determined. That's essentially a presumptive approach, and we've heard many times across these hearings about where an employer has to prove there is no link between a workplace and a mental health injury rather than the employee having to prove the link. So could a legislative amendment be made to the SRC Act to introduce this presumption?

Ms Anderson: I have been listening to some of the evidence around that today, and I might make a couple of points.

Senator URQUHART: I'm also interested in whether this has come up in any of the consultations, and what risks are there from such an approach?

Ms Anderson: Obviously from the department's perspective, we monitor developments, both in Australia and internationally, in this space. A couple of points I'd make on that is that it is important to take into account the different characteristics and circumstances of other schemes when considering developments such as these, and to consider the evidence is obviously critical in terms of policy development. My understanding of what is being considered or put forward by some witnesses is to introduce presumptive provisions which would mean, say, a first responder wouldn't have to prove mental health injuries, such as PTSD, was caused by their work.

I would just emphasise that showing that the injury is work related is only one element of the claims process and, for example, things like delays in lodgement of a claim can result in significant delays to access to compensation—and, as you mentioned, ensuring there is appropriate medical evidence that the person has suffered an injury can also cause delays. I would just put that note in—that a presumptive provision isn't necessarily a silver bullet. As a lot of people have mentioned, it's quite a complex issue.

From a policy perspective, in terms of what the department is looking at, a first step is to establish whether determining if an injury is work related is in fact delaying claims. We need to look at the data and the evidence around that. We are certainly in discussions regularly with Comcare. We are looking at the data that Comcare has around this. As Commissioner Colvin mentioned just previously, the AFP have contacted the department as well, so we will have further discussions with the AFP about this issue as well. So I'd probably just put a range of caveats around that.

In terms of consultation, we probably haven't had any specific consultation broadly on this particular issue recently—

Senator URQUHART: Apart from with the AFP, obviously.

Ms Anderson: With the AFP, and obviously we deal with Comcare regularly. We also have various forums. We are involved with Safe Work Australia and through Comcare get feedback from regulators as well. We've got that ability to get that information, but there is probably nothing specific at this stage that I can advise.

Senator URQUHART: In terms of the consultation that you've been having with stakeholders, unions, agencies and health practitioners on the SRC Act, there are six proposed changes that have been flagged there. They appear quite strong in principle. Do you see any issues in the implementation of those six changes? They are things like: timely access to compensation; up-front assessment of compensation needs; workers provided with early access to medical treatment before a claim is determined; medical treatment support provided by registered or accredited professionals et cetera et cetera.

Mr Cains: They're certainly issues that we've been working through and speaking to stakeholders about, identifying potential unintended consequences with those provisions. Certainly the intention would be that they would improve the scheme. Some of those amendments are actually based on recommendations of a major review of the SRC Act that was undertaken in 2012, where there was also very extensive consultation undertaken with stakeholders. We certainly think that there is some work that provisions such as these could do to improve the scheme.

Senator URQUHART: Do you think there are any major issues in implementing any of those changes to the act?

Mr Cains: The provisions would be designed to overcome any implementation-type issues.

Senator URQUHART: Under the Fair Work Act, how many claims of bullying have been heard from first responders?

Mr Breen: We'd have to take that on notice.

Senator URQUHART: Your submission notes that they can be heard by a third party at a relatively low cost. What is that cost and who bears the cost of having those claims heard?

Mr Breen: Applications for a stop-bullying order? We'll have to take that on notice as well. This is specifically around the cost of third-party hearings, is it?

Senator URQUHART: Yes—claims of bullying from first responders. Under the Fair Work Act, how many claims of bullying have been heard from first responders? In your submission, you note that they could be heard by a third party at a relatively low cost. That's actually in your submission. I'm wondering what that cost is and who bears those costs. Are you taking all that on notice?

Mr Breen: Yes.

Senator URQUHART: Your submission also notes that the SRC Act doesn't incentivise early and effective return to work for injured employees. Do you have a view on why this is the case and what can be done to change that?

Mr Cains: One of the criticisms of the SRC Act that came about in the conduct of the review is that it is quite focused on injuries and compensation. Efforts were made in developing legislation that was subsequently introduced into the parliament, and that we've consulted on since, to have the focus shift more to employees rehabilitating at work where possible or returning to work early. Certainly studies demonstrate that being at work is good for employees and good in terms of rehabilitation outcomes.

Senator URQUHART: Do you think the proposed changes to the act that address early rehab go far enough to protect and encourage injured workers to return to work?

Mr Cains: Yes.

Senator URQUHART: They do?

Mr Cains: Yes.

Senator URQUHART: I have a few questions for Safe Work Australia. Ms Baxter, in your submission you note that only '711 serious workers compensation claims were accepted per year for first responders' due to mental health issues. Can you tell me how many were lodged?

Ms Baxter: I will check with my colleagues.

Mr Garred: We would have to take that on notice. We would have that data but I don't have that in front of me.

Senator URQUHART: Okay; if you could that on notice. Would there be significantly more than 711?

Mr Garred: I couldn't say off the top of my head.

Senator URQUHART: Can you also take on notice the average time between lodgement and acceptance of claims for first responders due to mental health issues?

Mr Garred: I'll have a look at whether we are able to do that with our dataset. So we will take that on notice.

Senator URQUHART: And also the average time between lodgement and rejection?

Mr Garred: Yes.

Senator URQUHART: Can you tell me what percentage of workers compensation claims from first responders are due to mental health issues? You do keep that data, don't you?

Mr Garred: Yes. I just don't have the total number of claims for first responders in front of me; I've only got the number for mental disorder claims.

Senator URQUHART: What are they?

Mr Garred: That's the 711.

Senator URQUHART: Oh, that's what you've got. So you can't give me the percentage of how many of those that are accepted are due to mental health issues?

Mr Garred: No; sorry. I don't have that in front of me. I'll take that on notice.

Senator URQUHART: I don't know whether this is correct, but my understanding is that paramedics and ambulance officer claims for workers compensation are increasing. Do you know by how much over the previous decade?

Mr Garred: In figure 2 of our submission we provide a time series of the number of mental disorder claims for first responders broken down by the different services. That shows that the number of claims for ambulance officers and paramedics have increased—and that's for the last decade. They've increased from just over 60 to—

Senator URQUHART: Yes, they have. That's the numbers, but can you tell me why? What are some of reasons that that is increasing?

Mr Garred: I am unable to provide an answer to—

Senator URQUHART: You don't take that information?

Ms Raven: There are various factors that would be influencing the trend in claims, including arrangements within particular workers compensation schemes. So where there has been a change or introduction of presumptive legislation, you may expect to see a change in claims.

Senator URQUHART: Do you keep that information?

Ms Raven: In terms of legislative amendments that the jurisdictions are making, we maintain a watching brief through our strategic issues group on workers compensation, which includes jurisdictional members and—

Senator URQUHART: So would you be able to take that question on why they are increasing and then correlate that to maybe some legislative change or other reasons?

Ms Raven: 'Correlate' is probably too strong a word. I think you could analyse both sets of information to build a bigger picture. But in terms of associating a direct correlation—

Senator URQUHART: Is that something that you could take on notice?

Mr Garred: We'd be able to look at the particular changes over that period of time and note those, yes.

Ms Raven: It is important to note that there would be a range of other factors which Safe Work Australia would not have information about. So this would be just one small part of—

Senator URQUHART: Yes, it would be one small part, but it would at least tell a part of a story.

Of the three identified categories of traumatic stress as leading to PTSD, which one, if any, is able to be mitigated by workplace safety legislation or policy? With some of the stresses that lead to PTSD, can you step me through what sort of legislation or policy could maybe mitigate it?

Ms Johnston: The model work health and safety laws apply to all workplace risks in the same manner. The steps that you take to eliminate or minimise risk would apply to all workplace stresses.

Senator URQUHART: All right. That's all I have.

ACTING CHAIR: Senator Patrick, you have the call.

Senator PATRICK: This is mainly directed at Safe Work. You've said this legislation has been rolled out across four of the six states. How do those laws intersect with, say, the active steps the AFP are taking in respect of the Phoenix response and ANAO response?

Ms Baxter: Do you mean the work health and safety laws model?

Senator PATRICK: Yes.

Ms Baxter: And this is including the Northern Territory and Australian Capital Territory?

Senator PATRICK: Yes.

Ms Baxter: How do they intersect? Of course, the AFP would be covered by the Commonwealth Work Health and Safety Act, so I think it may be more appropriate for the department that has policy responsibility to respond.

Ms Anderson: Broadly, the AFP would have the same coverage as a Commonwealth employer, so, in terms of their responsibilities under the WHS law, I suppose that would intersect with what they need to consider when they're looking at the ANAO report and things like that. They obviously have obligations under the WHS Act that they would have to take into consideration. Is that where you're—

Senator PATRICK: Where I'm going is that all laws are designed to modify conduct. You have in this case a federal law that places an obligation on the AFP command or leadership, but they, perhaps independently, have been addressing the problem—which is a good thing. I'm just wondering how the laws are actually being effective in terms of adjusting conduct, noting the caveat that's clearly one of those legal terms—'reasonably practicable'—which I guess is open to all manner of interpretation.

Ms Anderson: I don't mean to handball back to Safe Work here, but I probably would note at this stage that there is an independent review being undertaken into the model WHS laws conducted by Marie Boland for Safe Work Australia. Certainly psychological injury is part of that review, and I suppose that review would also consider the model WHS laws and how effective they are in this space. So that's under consideration at the moment.

Senator PATRICK: Have you looked specifically at the AFP and their response in relation to these laws?

Ms Baxter: I'm not sure that a submission was received from the AFP by Ms Boland. Ms Boland has been appointed as an independent reviewer of the model laws. We in the Safe Work Australia agency are providing assistance to Ms Boland, but, to the best of my knowledge—and, if I'm wrong, I will correct the record—there was no submission received from the AFP, and I don't believe any consultation was held with them. I'm just confirming that with the department, who would have been the conduit through to other Commonwealth agencies and departments.

Senator PATRICK: What's your view on what 'reasonably practicable' means? Is that reasonably practicable within the context of an existing budget, or is it reasonably practicable in the context of a community expectation? How does one interpret that? How would you give guidance to an agency on how they interpret those words?

Ms Baxter: Safe Work Australia wouldn't give that guidance. As I indicated in my opening statement, we don't have responsibility for implementation, enforcement or compliance of the model laws. The model laws have been picked up by jurisdictions and made a law of their jurisdiction, and it is the jurisdiction who has the responsibility for educating, enforcing and ensuring compliance. Maybe Ms Taylor from Comcare—it's great all being here!

Ms Taylor: It's lucky I came back! We're the work health and safety regulator for the Commonwealth jurisdiction and therefore have the AFP under our wing in that respect. As for the term 'reasonably practicable', there are many elements to it and every situation is different. It's an assessment our inspectors make on a daily basis. It can go to cost, but it can also go to application of standards, implementation of practices, assessment of risks and the mitigation strategy. Usually you'll start with what the risk is and the assessment of the risk. Then there is what the mitigation strategies are and whether those mitigation strategies are reasonably practicable measures to put in place. Are there others that should have been put in place that were reasonably practicable too? Every situation is different and open to interpretation, but our inspectors, as I say, face this on a daily basis when they're out in workplaces to investigate incidents and notifications. It is an assessment that takes into account the particular circumstances. So I can't give a blanket answer that, yes, it's these five things that you would tick off in every situation.

Senator PATRICK: Correct me if I'm wrong. If I were an agency head, I could also take that to be, in some sense, an escape clause because it's not well defined.

Ms Baxter: There is some guidance in the model work health and safety legislation at section 18, and we could take you through that. It's reasonably lengthy, though, in terms of 'reasonably practicable,' but I just note that cost is really the last consideration to be had when considering what is reasonably practicable.

Senator PATRICK: And the regulations give some priority order, or it just has to be last on the list?

Ms Johnston: It is last. Section 18 provides that, after doing all the other assessments of the first four factors, then you look at the cost and whether it's disproportionate to the risk.

Senator PATRICK: Okay. I can have a look at section 18.

In terms of Safe Work, I note the statistics run out in 2015-16 in the submission that you've made. Of course, we've heard the AFP commissioner saying that, in the case of his officers, they've had a substantial increase in the number of claims that are being made. I'm just wondering if there is some reason this diagram kind of cuts off at 2015-16.

Mr Garred: At the time of us lodging the submission, 2015-16 was the latest data that we had available. We compile the national data set annually based on data that we receive from each of the jurisdictional authorities. Since we lodged the submission, we have finalised the 2016-17 data, so we are able to provide an update to the data in the submission on notice if you would like that. But I don't expect that it would change the story significantly from what's outlined in the submission.

Senator PATRICK: From looking at police, which I presume in your context is the AFP—or does this cover—

Mr Garred: That's a national figure, so that covers all police.

Senator PATRICK: So the AFP's increase in numbers, in some sense, might be hidden amongst the other data.

Mr Garred: Yes. It's quite possible that that chart would continue to trend up.

Senator PATRICK: Okay. This is perhaps my fault more than anything you're doing, but there are these responsibilities spread across three different domains here and including the agency. I don't even know who to ask this question, but, at your level, are you satisfied that there's proper coordination between the functions that are performed by your own organisation in terms of policy: the Safe Work, Comcare and, indeed, the heads of the various different jurisdictions that these laws apply to?

Ms Anderson: We have a range of mechanisms for talking to each other as well as to other jurisdictions. We do liaise with Comcare and Safe Work Australia on a very regular basis, so we are interacting between agencies. In terms of recent developments, the department has also established a working group of deputy secretaries across agencies within the Commonwealth to consider policy issues more broadly in respect of workers compensation. As I mentioned earlier, as a member of Safe Work Australia, we've got a lot of visibility of what's being discussed and what issues states and territories, as well as the social partners, employer associations and the ACTU are raising. So, from my perspective, we do have a lot of methods for consultation, and we're happy to sit down and talk to you in more detail about what the agency's and Comcare's responsibilities are in this space, and what Safe Work's—because it could look confusing from the outside but, from our perspective, there are very firm structures there; there are firm processes in place.

Senator PATRICK: Is there some sort of diagram? Who was that minister who did that diagram?

Ms Anderson: If that would assist you, we can certainly provide a diagram.

Mr Breen: I was just going to add, Senator, if it assists, very briefly: Safe Work Australia, as Ms Baxter described, is a multijurisdictional body that was formed to put together the model work health and safety laws. They were developed and finalised in 2011, but it was up to each jurisdiction—the Commonwealth and all the states and territories—to implement those laws within the jurisdiction. There was a bit of fine-tuning, and there might be a few variances, but essentially the bulk of those model laws were adopted certainly in the Commonwealth. So, that law is the Work Health and Safety Act 2011, which commenced in 2012 and applies in the Commonwealth jurisdiction, and that applies to the AFP within that jurisdiction.

Senator PATRICK: We heard evidence from the Police Federation of Australia who had a recommendation for solving the mental health problem through COAG, for example. The fact that there are different jurisdictions with perhaps slightly different legislation wouldn't affect the ability for COAG to work together?

Mr Breen: No. But I suppose, just to make the observation, we do have a framework within the Safe Work Australia construct which is subject to the agreement of members. As Ms Baxter pointed out, it's a member based organisation representing the various jurisdictions and the employer and employee representatives. That is a

nationally focused body that might, subject to agreement of members, be able to enter that space. Safe Work Australia might have more to add on that, but I think in broad terms that would be a possibility.

Ms Anderson: In terms of our portfolio, we do have the workplace relations and work health safety minister's council within that—ministers attend there from the Commonwealth; obviously the Commonwealth minister and the states and territories ministers. So, that forum also exists to talk to the jurisdictions about work health and safety matters.

Senator PATRICK: In your submission, you mentioned a group of people that I don't think the inquiry has come across. You talked about first responders in the police force, in firefighting, at AirServices. Then you've got crisis response workers from foreign affairs, defence and trade. Is that a big group of people? Often DFAT send police—the AFP—in or others?

Mr Breen: I wouldn't imagine it's a large cohort. It's more to address the scenario where, for example, DFAT officers are in a situation where an emergency arises overseas and they might be first responders, so to speak, in that context.

Senator PATRICK: Okay, so you're talking about people who might be consular people?

Mr Breen: For example, yes.

Ms Anderson: I can add to that: it may be some of the AusAID or aid workers who respond first in certain circumstances, but it's not a big cohort.

Senator PATRICK: Yes. So people who are funded by AusAID are not covered in this respect, are they?

Ms Taylor: They're not covered, no, but some of the actual DFAT and AusAID staff in some of these locations overseas may indeed be right on the spot when something happens. But it's a very small cohort.

ACTING CHAIR: There being no further questions, I think we'll let you go slightly ahead of schedule. Thank you very much for your attendance today.

MORGAN, Mr Dominic, Chief Executive, New South Wales Ambulance

[16:10]

ACTING CHAIR: I now welcome Mr Dominic Morgan from the New South Wales Ambulance service. I understand that information on parliamentary privilege and the protection of witnesses and evidence has been provided to you. I'd like to invite you to make some opening remarks, if you want to, and then we'll ask you some questions.

Mr Morgan: If it would suit the chair, I'm aware the New South Wales government didn't make a submission and, if I may take just a few minutes extra, I think it'd be worthwhile describing a little bit about our wellbeing and support program to assist the chair.

ACTING CHAIR: Yes, I'm happy for you to do that.

Mr Morgan: Firstly, I commence by acknowledging the traditional custodians of the land upon which we meet and pay my respects to elders past and present. I thank you for the opportunity to address the committee. New South Wales Ambulance is very pleased to appear in relation to how we're working to support the mental health and wellbeing of our staff. This is a key priority for New South Wales Ambulance and the committee more generally, given the unique role that paramedics have in health care and the emergency services sector.

It may be useful to give some background to the committee on this organisation's journey. I commenced with New South Wales Ambulance in the role of chief executive in 2016. I'd previously worked with New South Wales Ambulance as an operational paramedic and manager until 2009, before leaving to work in another jurisdiction. Upon returning to New South Wales, I undertook a listening tour around the state, hearing the issues of concern of staff. I was struck by the consistency of the advice I was receiving from the workforce that mental health and wellbeing and occupational violence protection were of significant concern.

Within six weeks of my return, I announced that we would hold the first ever Australian ambulance wellbeing and resilience summit, which occurred in July 2016. The summit was attended by every chief executive in Australia and New Zealand, and by more than 350 staff from all around the state. Many, in their own time, contributed to nearly 1,000 different ideas for the improvement of mental health and resilience for our workforce, and those ideas have been the cornerstone of our approach for the last two years or so. This has assisted in developing our strategic approach to these issues, and it may be worthwhile spending some time briefly describing the outputs.

New South Wales Ambulance has actively engaged in research in first-responder mental health, which continues to advance, and this has greatly informed the development of new programs and services in recent years. During this time we've had the opportunity to consult with international colleagues from the Mental Health Commission of Canada and work with local industry experts. In 2016, New South Wales Ambulance had its first summit, which I referred to. This was a key opportunity for us to engage and consult with staff about their wellbeing. Over a quarter of our staff submitted their comments and suggestions.

Supported by funding provided by the New South Wales government, we commenced addressing these opportunities, either building on what was already in place or implementing new initiatives. Key initiatives include a wellbeing workshop. The first wellbeing workshop for all staff was held in March 2018. Since that day we've had over 913 staff go through our workshops. Over the next three years, all staff will have completed the workshop. Since August 2018, new staff—both paramedics and call-takers—have the workshop material included in induction training. The workshop is an integrated wellbeing training course, which includes an evidence based resilience and mental health component, complemented by RAW Mind Coach—an online program available to all staff which is resilience at work. This workshop program also includes training in relation to health and fitness, manual handling and occupational violence prevention, all of which contribute to employee mental health.

Significant events: anyone who is involved with emergency service providers is aware of the impact that attending certain types of jobs can have on first responders. The impact may be immediate from that particular incident or may be a cumulative effect. NSW Ambulance implemented the significant events register in July 2016, which requires all managers to record any event that may have a potentially harmful impact on the attending staff. The staff are actively followed up and offered support services. Senior managers are responsible for reviewing the register and ensuring follow-up has occurred. In May 2017, I personally wrote to all managers and educators and advised them of my expectations and their responsibilities to ensure that follow-up occurs and support is provided. I require any manager aware of any event to follow up, not just the employee's direct manager.

All NSW Ambulance managers have written policies, procedures and instructions to release any staff member from duty following significant events where appropriate. That instruction includes both on-road paramedics and

our call takers dealing with significant triple 0 calls. Significant events are, in some ways, an obvious trigger for asking a staff member if they need help, but we need all staff to be conscious both of their own and their workmates' mental health. We know that such issues can often be well hidden and are not acknowledged. The wellbeing workshop assists with this, but we're also attempting to reduce the stigma of mental health by having it at the forefront of our communications, and matching services and training available to all staff.

In February 2018, we commenced our own staff psychology service and our chief psychologist was appointed. Two additional appointments have been made recently, and we wish to roll this program out to each operational work area. These registered health professionals are on the ground and will develop a good understanding of our agency and our work, which will enable them to deliver professional assistance in a timely manner. Importantly, by knowing the staff in their work area we're optimistic that this will build trust and facilitate earlier help seeking for mental health concerns.

Like the rest of the public sector, NSW Ambulance staff can contact the Employee Assistance Program and psychological services for specialist counselling or psychological service. It's an external third-party provider, which some people feel more comfortable with, and additionally it offers staff trauma assist and manager assistance 24/7.

Since 2016 NSW Ambulance staff have also been afforded the opportunity to attend up to 10 sessions with a psychologist or psychiatrist of their choice at no cost to them. This does not have to be related to a workers compensation claim nor does the issue need to be work related. Coupled with the psychologist, at a more informal level are the peer support officers and chaplains. Both programs have recently been expanded.

At the beginning of 2018, 33 new peer support officers were trained, taking the total number to 209. A further 29 staff are on an eligibility list ready to commence training. In April this year, we recruited a further eight chaplains, taking the team to 48. We're planning to add another 19 to our team of Christian, Jewish and Muslim pastoral carers and more evenly distribute them throughout the state. Our intention in the next few months is to combine all these services in to a staff health unit, so it is easier for every staff member and every manager to have a one-stop shop where they can go to get advice and support.

We're also working to further develop our managers. NSW Ambulance is investing in our managers to ensure they're better equipped to deal with managing people and complex mental health issues. This is what we call our capable leader strategy. This month our leadership coach commenced. Her role will be to work with our managers around their capability development, and help enhance our strong, supportive and capable management team into the future. As well as requiring our managers to complete the wellbeing workshop and to follow-up with staff appearing on the significant events register, they're being trained to identify significant mental health issues and how to have supportive conversations around this area. Suicide awareness training for managers commenced in July 2018, and it is anticipated that all managers will have completed this training within the next 12 months.

There are additional things that can be done to improve the working life of our staff, hopefully reducing their day-to-day stress and leaving them with greater resilience to deal with the big issues. We've also introduced a therapy dog to our control centre. It's a complex and busy work area. Sometimes just the presence alone can alleviate the stress of call after call of people needing assistance. The impact is truly remarkable.

We recognise that there is a link between fitness, mental health and psychological resilience, and support and promote Fitness Passport. The passport allows our staff and their families to access hundreds of gyms and swimming centres across the state at reduced membership rates. To date, about a third of our staff and their families have signed up.

We utilise a buddy system for staff. This might relate to new recruits or equally to staff with an extensive history but who have moved to a new work area. The buddy provides help with basic things, such as logistics around the ambulance station and local services, but equally is a sounding board for other, more serious, concerns, such as workplace relations, clinical issues and career advice.

Whilst the focus has been on what is directly in front of us, we're now turning our mind to those closest to them—the families. Since March 2017, the Supporting our Families program has been running. The program helps our paramedics' families to more fully understand what it is that the paramedic job entails, how they can recognise signs of stress or mental illness in their loved one and what they can do to assist them to get well, stay healthy and get appropriate help.

We have also recognised an employee's connection with NSW Ambulance does not end when they retire or leave employment and that the impact of emergency service work can continue into retirement, which in turn continues our obligation to our staff. To support our retired staff, NSW Ambulance Legacy was created in 2017. Its role is to assist members who have separated, retired or are retiring by providing support, enduring social

connections and events, an ongoing sense of belonging and real, continuing involvement with NSW Ambulance colleagues. Peer support officers and chaplains will also be available to NSW Ambulance Legacy members following the official launch later this month.

In closing, I consider that the Senate committee is in a strong position to make a number of recommendations that could benefit all emergency services personnel across the country. The Commonwealth government is well-placed to provide leadership and support with respect to best practice workplace mental health strategies for first responders that will enable them to access the services they need, irrespective of jurisdictional capacity. I look forward to discussing that in more detail today.

NSW Ambulance believe that important areas of focus include the provision of tailored and customised treatment pathways, including recovery focused workers compensation programs, assistance for families and post-employment support. We are finalising our 2019-21 mental health strategy, to be released next year. We've ensured our policy is aligned to the better practice framework for mental health and wellbeing in first responder organisations, the mental health and wellbeing strategy for first responder organisations in New South Wales, the Council of Ambulance Authorities mental health and workplace strategy, and the Canadian psychological health and safety in the paramedic service organisations strategies.

Again, I thank the committee for inviting me to attend today and am more than happy to expand on any of the programs or strategies that I've touched on in this opening. Importantly, we look forward to your findings and incorporating any recommendations that will assist or prevent our staff from experiencing mental health issues as a result of their chosen career as a first responder.

ACTING CHAIR: Thank you, Mr Morgan. Is it possible to get a copy of the statement tabled?

Mr Morgan: Certainly.

ACTING CHAIR: That would assist not only committee members but also Hansard. It's probably a more minor part of the very extensive list of activities you are undertaking there, but the therapy dog does interest me. Where did that come from and how does the arrangement actually work? Do you go to an outsourced provider? Have you just gone and bought a pup?

Mr Morgan: It came from Canada. There were some interesting case studies a few years ago, where the Canadians were moving to what I would describe as a 'superstation' model, and they noticed that having a dog in the workplace was really well regarded. It's very hard for people to stay angry at a dog, as you can imagine. Our Sydney control centre is the busiest 000 call centre in the Southern Hemisphere, and it is a high-pressure environment for anyone to work in. The manager in that centre decided that it would be worthwhile to bring in therapy dogs, just for a visit, as it started. I was fortunate enough to be there the first day the therapy dogs were brought in. It was truly amazing seeing grown adults sitting on the floor in this high-pressure environment and absolutely engaging with these animals. The carers tell us that they're of the view that these dogs absolutely know the people who are in distress and know who to go for, and they target them.

That evolved into the outsourced therapy dogs going every Wednesday, and we've now just been offered a guide dog, which wasn't able to get through guide dog training because it had persistent ear infections, sadly. It's difficult for vision impaired people to care for the dog. For that reason alone, the dog couldn't go forward. The manager of the Sydney control centre is now going to care for that dog. We're going to reimburse her for the costs of that. They've organised the schedule within the Sydney control centre so that the dog will come to work every single shift and the staff will take turns caring for the dog and taking it for a walk. You can imagine what a great interrupter this is of the pressure of taking triple-0 call after triple-0 call. It's just one initiative that has been very, very successful in the eyes of the workforce.

ACTING CHAIR: In terms of your overall suite of packages, we've had a recurrent theme in that we know some things that hurt, we know some things that we're not sure about and we know some things that help. How confident are you that the suite you've put together and put in place errs on the side of the positive end of that ledger?

Mr Morgan: I think you've just leapt right into the nub of the question. I think we have solid programs. I think that in terms of where New South Wales ambulance was, relative to how far we've come in a few years, we've got to acknowledge that perhaps we as an organisation didn't recognise mental health and wellbeing issues as well as we should have in the past. I think we are in a solid position in terms of contemporary practice of what we know. But the nub of this question is why I firmly believe that this committee is entirely right: there is a role for the Commonwealth here. I'm currently doing some work with beyondblue in relation to the national mental health reporting. The results of that research will come out in the next three or four weeks. I can say that we have over 120,000 employed first responders in this country. We have over 300,000 volunteers who are first

responders and confronted. That's half a million Australians. Every single family member and spouse is impacted by the work of first responders. We're potentially talking about two million Australians directly impacted by the work of first responders, so it is a significant issue for the country.

I think the place of the Commonwealth in supporting us is that the alignment of best practice and the alignment of the research and the investment in having national best practice standards that all jurisdictions can adopt is critically important. It may be okay that New South Wales, as a very large state, can deliver solid programs. Queensland may be able to. Victoria may be able to. But it would be very difficult for our smaller jurisdictions to do things on the scale that the bigger states are doing them, and I would only rate our approach to it as solid. I think our ability to translate the research from the evidence into a funding stream into actual programs is not timely. I think that if the Commonwealth funded and set up best-practice think tanks, for want of a better word, and research into first responder mental health issues it would roll that clock forward in a very significant and meaningful way.

ACTING CHAIR: I'll hand over to my colleagues. I think a therapy dog is a great idea for this place—not that any of us need it, but I think some of our other colleagues might benefit from it!

Senator MOLAN: How many staff do you have?

Mr Morgan: By headcount, just short of 5,000. It's about 4½ thousand FTE.

Senator MOLAN: That's a tremendous list of activities that you've undertaken. Can you identify the cost of those initiatives, separate to your overall budget?

Mr Morgan: Yes, broadly, I can. The New South Wales government is investing, over four years, $30 million. On the year of my return—and certainly by the overwhelming feedback of the workforce—we put forward four business cases to government. They were called the capable leader, the protected paramedic, the safe paramedic, and the well paramedic. Those four business cases were thoroughly endorsed by government. In 2017 we received the funding that allowed us to build the programs that we're rolling out now.

Senator MOLAN: I think you volunteered, at the end of your submission, the article from June 2018 where you apologised—I think it was you: 'NSW Ambulance Service has admitted the organisation completely failed paramedics in trauma and mental health programs.' You gave us that, didn't you?

Mr Morgan: No, I didn't. But it was from me. I suppose we haven't managed things well in the past.

Senator MOLAN: I'm sorry; I didn't mean to bring that up—I thought you had.

Mr Morgan: No. It's quite legitimate to touch on this point. There is a long history of all first-responder organisations who have recognised issues faster or slower than others. There were many, many of my colleagues who, probably over my first 12 months—and continuing to this day—came and saw me and spoke about their experiences as they have lived them, sometimes dating back to the 1960s. In fact, only two weeks ago I had a person come to see me who joined the job in 1964, who just needed to be acknowledged over the experiences that they'd had. It was those experiences, and hearing people's journeys, that led me to form the view that it was essential to acknowledge it, and acknowledge it publicly.

Senator MOLAN: And that's great. I was interested in this article that has been provided to us through the documents that a number of times the word 'paramilitary' is used, and it's used in a critical way. As someone with a military background, I would ask how you interpret that word. One of our senators has used that word a couple of times.

Senator URQUHART: I have.

Senator MOLAN: I just wonder how you interpret that word.

Mr Morgan: We probably haven't got long enough to go through all of that, but I'm going to distil it down to time and place. There is no doubt that, in a major incident, when you're out in the field, it is necessary to be directive: 'We need this patient moved and we need this person's issues addressed now.' However, the subtlety of transposing that into a health environment—which we are, at its core—is challenging for some. In recognition of this, we recently rewrote all of our policies around bullying and harassment, for example, and removed requirements around chain of command. This was specifically done to give the workforce confidence that, if they raised an issue in the workplace—specifically if those issues were related to a manager—they could raise that issue with any manager in the organisation, and that manager had an obligation to act on the information they were provided or refer it to another manager who could. This was specifically in relation to bullying. A final plank to that is the communication I've directly had with the workforce on multiple occasions, and, if they still feel that the issues have not been resolved, they can raise them with me directly. And that's led to a number of the meetings I've had.

Senator MOLAN: So the term 'paramilitary' is used to imply that there's a directive and not a consensus approach to what people do?

Mr Morgan: Correct. At the risk of going down a rabbit hole, I think, in my time—when I came in as a paramedic—most of the leadership were males and most had been in for 10 or 15 years and had come out of the back of the Vietnam War and knew a particular style of management and leadership. We are not saying that that was wrong; what we're saying is that there is now another way that we can approach cultural change and leadership development that actually leads to outcomes that better support our staff. That means we're not throwing away the important, valuable things that allow us to do our job in an emergency situation, but it is saying that on a day-to-day basis of staff engagement, command and control are largely anachronistic.

Senator MOLAN: Absolutely. You've provided such a tremendous example of what appears to be great leadership and the doing of things, but you've also said that the Commonwealth has a coordinative role in this, and just about everyone else has said that. I'm interested in what you particularly mean by the Commonwealth's role. I mean you've got out there and done it and so have others.

Mr Morgan: I think it largely sits in the research and the best practice. I may have a particular interest. My chief executive colleagues within ambulance services across this country and New Zealand, I know, have a personal commitment to this but that doesn't necessarily mean it's systematised. I think the opportunity for the Commonwealth is in research, best practice and pulling together the best of what's being done right across the country to allow leadership to adopt those initiatives as best practice, or come up with innovative ways of how, for example, smaller jurisdictions might be supported.

We're rolling out our staff psychology service. We have funding for a chief psychologist. We will probably end up with nine senior staff psychologists. The ACT will not be able to do that. The Northern Territory is unlikely to be able to do that. Tassie is unlikely to be able to do that. So how do we take that and say, 'What's another way that we can achieve scale right across this country?' Bringing together the elements that make a really robust mental health and support system, I think, is a role that the Commonwealth could play well.

Senator MOLAN: That's tremendous. Thank you very much.

Senator URQUHART: Thank you, Mr Morgan. I was pleased to read your first paragraph in your opening statement. I wonder what happened in Sydney a month ago when you weren't pleased to turn up?

Mr Morgan: I'm sorry?

Senator URQUHART: You pulled out at the last minute. What happened?

Mr Morgan: Thank you for raising the issue. Can I say I would like—

Senator URQUHART: I did give you a bit of a flogging at the Sydney hearing on a number of occasions!

Mr Morgan: Thank you so much, Senator! Facetiousness on my part aside, I hope it's been made clear and the committee understands NSW Ambulance did not decline. We were on the agenda to come. We were advised, in the days preceding that, by government that we wouldn't be required to attend. I was subsequently advised that Fire and Rescue NSW would be representing the New South Wales government. I was very strongly of the view that it was important for NSW Ambulance to attend, and described NSW Ambulance's journey—because it is a journey and we've come from a challenging base to have a lot more work to do. It was important for us to tell our story with the support of our minister. And with a very timely invitation from the committee—thank you very much—we were able to achieve my attendance here today.

ACTING CHAIR: Thank you. We appreciate it.

Senator URQUHART: Good. I want to go back to the June apology to the workforce. How have you addressed the concerns that real support isn't flowing fast enough? In your apology, you talked about how some measures had been implemented and others were still in progress. Can you take us through what's been implemented, the successes and failures in the short term, what hasn't yet been implemented and why, and when it will be? In a condensed form, because I've got a lot of questions—

Mr Morgan: Perhaps—

Senator URQUHART: You've been through all the programs that you're implementing. Is that generally—

Mr Morgan: There are many that we've been working on. I think, perhaps, it would be useful for me to turn my mind to future things that we're working on, because I think that that's where we'll get some real benefit. I think the real area that we want to continue to undertake significant further action on is around research into first responders. We know programs now that will help individuals, and the research is supporting where we can assist individuals to become more resilient.

It's my considered view that there are far more factors at play here than just individual resilience. There is a very good paper that Professor Sam Harvey released earlier this year into the psychosocial safety climate. One factor is the role of leadership development, management development, and the ability of staff to not only have the confidence to raise a concern about mental health but also have trust that declaring that will be managed properly by their leader. So, for us, capable leadership is a significant way into the future. I think activity and acuity of workload is a significant factor here yet to be properly explored in the research.

We really want to expand the families program. We are only dipping our toes in the water with this, to the extent that we're providing information to families of inductees and essentially giving them reference points to call if they have any concerns in relation to identified behaviours with the one that they love. What we really want to do is expand this out into local volunteer networks within the broader ambulance service so that there's a local family support. This goes to the heart of trust and confidence that individuals will have in coming forward and speaking to someone that they know about concerns about the mental health and wellbeing of their loved ones.

Senator URQUHART: If there are any others, could you provide them on notice?

Mr Morgan: We can.

Senator URQUHART: I think it would be good to have that information on what you've done. Your apology was pretty strong—that you'd 'completely failed paramedics'. So to then talk about what the successes are and what you're yet to implement would be useful.

Mr Morgan: There are two big things that will be important for NSW Ambulance. One will be the Staff Health Unit. We've got a lot of programs moving at the moment, but I think the core of bringing the Staff Health Unit together to manage our staff psychology service, the employee assistance program, the chaplaincy program and the peer support program and interfixing all of that around the physical aspects of mental health and wellbeing will build the cadence and the rhythm of the organisation to deal with the issue holistically—whereas, a lot of what we have been doing is foundational.

The next big thing that I've referred to, which is going to be key to our future and, frankly, trust with the workforce, is around the notion of Employee Connect. One of the things that has been raised with me by individual staff members at different times is, 'Who's in my corner?' I'm sure the committee has heard by now that one of the first things to be impacted when you're not well is the loss of trust in your employer. We want to set up a system where there is a positive responsibility on the people who work in Employee Connect that, when they get contacted by a staff member to say, 'I think I have this issue,' they don't get bombarded by, 'Well, you need to look at policy No. 376. You need to go and talk to this person.'

Senator URQUHART: To be fair, Mr Morgan, the issue is that the trust needs to come before that. The issue that we've been hearing consistently through this inquiry is that, at that first point where they just want to talk to someone, their superior, they don't have the trust in that person for their issue to remain confidential, or that they'll even have empathy about it. So I think that comes before that.

Mr Morgan: Yes. I could probably talk a little bit about what we're doing to engender that trust.

Senator URQUHART: I'm actually really happy for you to take it on notice. I wrote down about 12 things that you talked about with programs. I'd be really interested to have a look at the programs that you've put and their status—whether they're partly implemented or fully implemented—and you're going to measure them to see whether they are effective.

Mr Morgan: I am more than happy to do that.

Senator URQUHART: That would be great. Just after the apology that you provided in June, the New South Wales Legislative Council handed down a pretty damning report into bullying in first responder organisations in New South Wales. Has the NSW Ambulance Service formally responded to that report?

Mr Morgan: I think the Office of Emergency Management is responding on behalf of the government. We have certainly had input to it. This is a really important topic that you raise, going to the issue of trust. One of the ways we measure that trust and the changing culture of the organisation is through the 'People Matter' employee survey.

Senator URQUHART: I want to go back to the recommendations that you have adopted and the progress on implementation. From that report of the New South Wales Legislative Council, could you provide the recommendations that were relevant to NSW Ambulance—and I know there were broader ones that were relevant to others—

Mr Morgan: Yes, there were three that were specific to NSW Ambulance.

Senator URQUHART: which ones you have adopted and your progress on the implementation of that.

Mr Morgan: I would be confident that that would be something government would be responding to. They haven't responded to it formally yet. But I'm happy to take it on notice and they will respond accordingly.

Senator URQUHART: Okay, great. We have talked about military management. One of the main concerns we have heard about NSW Ambulance and other ambulance organisations across the country is that they are run like paramilitary organisations. I raise that again.

Senator MOLAN: I'm not objecting. I just wanted to understand how you are using the term.

Senator URQUHART: You have trained professionals who need the freedom to take calculated risks, which they do on the job—they are confronted with all sorts of things—and make informed proposals about that. Can you tell us how you are changing the culture in NSW Ambulance. What are you doing to equip your middle managers with greater skills in that area but also in terms of managing mental health in the workplace? You talked about some of the programs you have got, but I'm particularly interested in whether you are aware of the Black Dog Institute's work at the University of New South Wales with Fire and Emergency Services. We heard about that at the hearing in New South Wales. It sounds like some really good work is being done with the trial that they are doing with their middle managers. Is that something you have looked at?

Mr Morgan: Yes—and have been involved in, with Black Dog. In relation to the training currently provided to the managers—middle managers and first-line managers specifically—we have an ambulance management qualification, which they are all required to participate in. We have a multi-agency leadership program, Management Matters, which is an early way of bringing our budding leaders into the system to give them a taste of management. There are leadership toolbox talks that are facilitated by our leadership program centrally. We have Coaching for Performance workshops. We have induction programs for our senior managers. We also have, through NSW Health, very extensive online generalist management training and a leadership wellbeing program. Because the wellbeing workshops are run over three years, we needed to equip the managers early to know how to respond to the issues that might be raised through those workshops. In relation to specifically what the managers are being taught about mental health, we are currently rolling out suicide awareness training, which is well advanced now and will be completed within the next 12 months. We have Mental Health Management for Managers, we have Discrimination, Harassment and Bullying for Managers and we have just appointed our first leadership coach. We also have a Manager Assist program, which is to give real-time coaching and support to managers in dealing with difficult and complex mental health problems in real time.

Going to the heart of cultural change is, to say the least, challenging for any organisation. This is the essence of our Capable Leader program and a lot of it is designed out of the work that Professor Michael West has initiated around compassionate care and compassionate leadership. Michael West is the head of thought leadership at the King's Fund in the UK. His work has been incorporated through NSW Health, which ran an innovation symposium. We have used his work at our staff-patient experience summit. The principle is that you can only care for others when you care for yourself. We have done a lot of work around wellbeing, as we have discussed. I personally lead, with my deputy, a talk at every single wellbeing workshop. My deputy and I have committed to talk about culture and bullying at the beginning of these workshops every single Tuesday morning for the next three years.

Additionally, we have done a lot of work around values and values based leadership. The challenge we have is that we are a very large, complex and dispersed organisation. To continue to simply refer people to swathes of policy in this very complex area bears little outcome. A key focus of my discussions with the workforce is that, if you are ever in doubt as to which policy and procedure to follow, if you always fall back on your values you will never make a wrong decision.

Senator URQUHART: I understand that you were the head of the Tasmanian Ambulance Service before commencing in the role in New South Wales.

Mr Morgan: That's correct. Are you going to ask me about that jurisdiction?

Senator URQUHART: I am just going to ask about the culture of the Tasmanian service. Is it similar to New South Wales?

Mr Morgan: I did seek advice in relation to that particular matter, and I was advised that I am not at liberty to discuss another jurisdiction.

Senator URQUHART: You can't even talk about what strategies you implemented?

Mr Morgan: That was the advice I received. But I can answer anything you would like on New South Wales.

Senator URQUHART: I am really interested in whether you had good strategies in Tasmania and have tried to pick them up in New South Wales.

Mr Morgan: I stopped working in Tasmania in 2015. What I can say is that I think the journey of NSW Ambulance was unique, and the real catalyst was the workforce itself. The workforce was unambiguous. At every station, every town, that we went to, in one way or another, whether directly or obliquely, the workforce raised the issues of mental health and wellbeing and occupational violence.

Senator URQUHART: You didn't bring with you to New South Wales any training programs that you thought worked really well in Tasmania? Or do you just not want to talk about Tasmania at all?

Mr Morgan: That's the advice I have received.

ACTING CHAIR: I don't really see any particular barrier to answering those questions. Could you take it on notice and get some advice as to whether you can answer the question?

Mr Morgan: Certainly.

Senator URQUHART: It is a simple question. It goes to a point that we have heard a lot about in this inquiry, and that is whether there is a role for national leadership—and that the different jurisdictions don't always talk to one another, they have different forums. I'm talking not specifically about ambulance, but maybe firies, police and others. We have heard of really good ideas in some states, where it doesn't really correlate across to other jurisdictions—and I wonder why. So I guess that is why I am asking whether there were things that you implemented in Tassie that you have brought to New South Wales that you think are better than what was there, and is there a role for that national leadership?

Mr Morgan: Perhaps I can answer some of that. The Council of Ambulance Authorities, which represents every ambulance service in Australia and New Zealand, has its own mental health and wellbeing committee. It is a very active committee, and there is a lot of information sharing going on. Only recently, we had beyondblue addressing the Council of Ambulance Authorities board. I think I can confidently say that it is an issue at the forefront of the minds of the leadership of all of the services, and I am confident that that extends to Tasmania.

Senator URQUHART: We have heard a lot of evidence across the different jurisdictions about paramedics who self-medicate. They obviously have access to drugs and they have access to all sorts of different methods of dealing with their own issues. Can you take us through how NSW Ambulance manages and supports paramedics who may be stealing or taking drugs from somewhere or whatever, and give us examples of where they have done that to self-medicate for mental health injuries related to their work. How do you deal with those sorts of issues, when they are required to have access to those sorts of things to do their job? How do you manage that process?

Mr Morgan: There are slightly different issues here around, for example, opiates, which may not be the same as legally accessible drugs such as alcohol. Predominantly, I am on the record with the workforce as saying that, where people voluntarily raise with us that they have a bone fide drug or alcohol issue, first and foremost we will always treat it as a medical condition. However, if it is not declared to us, we may treat it as a medical condition. Sometimes these things can involve theft and a breach of duty of care and a whole range of things. In that regard, each case that wasn't declared will be treated on its merits.

Senator URQUHART: Is it a cry for help? It could be alcohol, opiates or whatever. Within all of those programs that you talked about, do you teach your leaders that that is maybe a cry for help?

Mr Morgan: Yes, very much so. In fact, one of the key points in the culture of bullying talk that I do is that unwellness will often manifest as bad behaviour. So people need to take a step back and consider not necessarily what is occurring directly in front of them but the causation of that. I have a personal opinion that the issue that is difficult for first-responder organisations is not so much the acutely traumatic event that happens in front of you—everybody sees the big car crash; we know what to do, and managers fall in behind that—but the subtlety of the cumulative effect of these things. It can take many, many years to manifest.

Senator PATRICK: 'Filling the bucket' is what we have been told.

Mr Morgan: That's absolutely right. It will start to manifest early on—in sick leave patterns, grievances, difficulties in the workplace and even assaults. With the benefit of hindsight, you can see from the development of patterns that there was a potential that these individuals were getting unwell. This is why I am so optimistic about the staff psychology service: because they are going to be out there and meeting these people and knowing these people, they are more likely to say they are in trouble than if they had to pick up the phone and bring someone they do not know.

Senator PATRICK: I'm going to be very forensic, Mr Morgan. I am looking at the Australian Paramedics Association submission to this inquiry. I want to run through a few points that they have raised and give you an opportunity to respond. Their submission talks positively but raises some issues, and those are the things that I

would like to talk to you about. In terms of the reporting of mental health conditions, under the heading 'Inadequate reporting mechanisms', it says:

NSWA does not have technology to enable the reporting of incidents in real time. This leads to significant underreporting of critical incidents. Furthermore, the technology provided to paramedics (such as EMRs) is often non-functional.

It goes on to say that it is basically cumbersome and difficult to make a report in your service.

Mr Morgan: What I can tell you is that, of the workforce that has recently gone through the wellbeing program—913 staff have been through it and 365 have completed the staff survey in relation to that—98 per cent said they would be 'more likely' to access or raise mental health issues to peer support—

Senator PATRICK: This is about the mechanism of reporting, not the willingness.

Mr Morgan: Okay. We have a number of things to do that. There is an incident management system, which is used by all of Health. I would certainly characterise that as first-generation technology.

Senator PATRICK: Is it real time?

Mr Morgan: It can be done in real time—not in an ambulance, but every station has access to record an incident in the IMS.

Importantly in the space of mental health, we have the significant events register, which is held with the sector officers out in the areas. Any incident can be categorised across four different severities and recorded in real time. Our significant events register policy and procedure details the actions that the managers have to take in relation to the two most severe categories. So that can happen in real time, whether there be a notification from the control centre, whether there is a notification to the duty operations manager or whether we simply become aware by it being entered by a paramedic into the incident information management system.

Senator PATRICK: Once again, I'll simply read this out. I know you've talked about culture, but:

NSWA has a workplace culture which categorises issues with mental health as inconsequential. It is not uncommon for us to be informed a circumstance in which a paramedic has confided in peers or managers that they are struggling to cope. This has been met with a lack of empathy and a suggestion akin to "suck it up, it is part of the job".

That's their submission into the inquiry.

Mr Morgan: Yes. I think this goes to history. It goes to what we have been doing to address these issues and what confidence I can give the committee that meaningful change is occurring around those issues.

Senator PATRICK: But this recognises a lot of what you've mentioned in a positive way. To be fair to you: I'm really just cherry-picking the steep criticisms that are in here. So it's not like this is a submission that's from two years ago; it's a submission that's kind of now.

Mr Morgan: Importantly, how I'd respond to that is that we have the People Matter Employee Survey that is done by the whole state service in New South Wales. In the last 12 months there was a four percentage point increase in staff engagement across NSW Ambulance. I will note that it's my view that this is off a low base, but there was every single indicator out of something like 58 questions which showed a positive improvement within NSW Ambulance. Importantly, within the top five of the nearly 2½ thousand staff that completed the survey was, 'Overall, I believe the culture in my organisation has improved in the last 12 months.'

Senator PATRICK: Okay. There are a number of good things, and then they come to the point that, in terms of workers' compensation, one of their criticisms is:

NSWA does a poor job of providing meaningful alternate duties where paramedics are given tasks of no meaning. Paramedics have reported that this increases their feelings of isolation while rehabilitating.

This goes to people who are being treated. What would you say to that criticism?

Mr Morgan: I think that 'meaningful duties' is the challenge of the term—'are the duties reasonable in the circumstances' versus 'what is meaningful to me'. I raised this same discussion with an employee, and he said to me, 'After being a paramedic, Dominic, what else is meaningful?' What we are doing specifically in relation to that is having a new executive director of people and culture. She's currently negotiating with the NGO sector for placements for paramedics within a healthcare setting that is actually not necessarily an acute healthcare setting. This is to actually get staff members back engaged in the workplace as early as possible. Historically, I think it's true that a lot of paramedics undertook administrative duties within sector administration offices and many found that not to be meaningful. Now, it was work that needed to be done, but, if you're a highly experienced clinician who is no longer responding to emergencies and now you're doing administrative duties, I actually understand why that is not considered meaningful for those individuals. But there are good inroads being made.

Another example of what we're looking at doing is placing appropriate people that might have a physical injury within the control centre so that they can do clinical call-backs on low acuity patients to check on their progress.

So there are a lot of initiatives in that regard in place, beginning and continuing to increase to ensure people get meaningful duties.

Senator PATRICK: Once again I emphasise that they have made a lot of positive comments and I'm being a little bit nasty and just pulling out the bad ones. My final point: they say in respect of workplace culture and management practices:

There are many examples of policies and procedures not being applied consistently by and to managers. A commitment to enforce policies designed to improve workplace culture … uniformly is crucial to improving workplace.

Mr Morgan: Specifically in response to that, I'd just say I would be happy to look at any examples that they've got where policy hasn't been followed, because it's there for a reason. It's mandatory.

Senator PATRICK: Do you engage with the association?

Mr Morgan: Very much so, yes. We have a whole framework around joint consultative arrangements with both the Australian Paramedics Association and the Health Services Union. We have local consultative arrangements where local managers, local staff and members of the unions can come together and discuss their local issues. Additionally, we have a statewide forum where issues that can't be resolved at those lower levels can be discussed and raised.

Senator PATRICK: I'm sure they will be listening in to the testimony today and they will take up that invitation.

Mr Morgan: We'd certainly love to look at the detail.

Senator PATRICK: Thank you very much for coming down to Canberra.

ACTING CHAIR: We really appreciate it, Mr Morgan. Thank you very much.

Mr Morgan: Thank you. I really appreciate the opportunity.

THOMSON, Ms Vivien Denise, Private capacity

[17:06]

ACTING CHAIR: Welcome. Is there anything you wish to add about the capacity in which you appear today?

Ms Thomson: I'm representing myself as a voluntary firefighter for over 31 years.

ACTING CHAIR: Thank you very much for being with us today. Would you like to make an opening statement?

Ms Thomson: Yes, I would, if you don't mind.

ACTING CHAIR: Please go ahead. Then we will ask you some questions.

Ms Thomson: Please do. First of all, I want to thank you very much for allowing time for me to come. It was at very short notice. When I started looking at the submissions online, I realised there weren't many at all from the volunteer component, so I felt very compelled to come along and share some voices and some stories. As I mentioned, I have been firefighting for over 31 years as both a paid and a volunteer firefighter, predominantly in the rural firefighting side. I've worked on all sides, including on fuel management, volunteer management and training. My experience base is mostly in operations, where I controlled many fires as an officer—sometimes up to three a day. That was here in the ACT. I have worked in both the ACT and New South Wales and at a national level on committees and boards, and I live and work on a farm, so I have a very strong understanding of a lot of the issues.

I put together seven recommendations and I was going to go through each one of those with just a paragraph underneath to explain, but my document, when I sat down to do it, ended up 10 pages long, so I've actually given that to the secretariat, and she will make a copy for you. It's quite in-depth in terms of why I'm making those recommendations. Even though this is a personal submission, this is a submission that comes from a lot of voices and a lot of people that I've spoken to over the last couple of weeks.

I also will be providing a copy of a book, which you will have. I really encourage you to have a look through that. There are nine separate stories in there, and a lot of this evidence comes from this book. You will not find another book like it. It's raw, it's real and it's volunteer firefighters predominantly. It tells the story like it is. When I put the book together, it was not edited out at all, so it's from a very strong rural firefighting perspective.

I will go to my first recommendation. We need specific trauma counsellors. A lot of the time we are not broken, although we have an inherent need to talk about what we've been through; we have a strong desire to share our stories. These counsellors need to be trained in this fact. Understanding what happened is a major factor in our recovery. There needs to be a proactive service before an event as well that is integrated into the brigade structures. Counsellors and support staff need to be trained in trauma and embedded in the volunteer structures.

That's the recommendation, but I'll back that up by saying recovery is a critical component of emergency, and it begins when the incident happens, in the early stages, but it generally focuses on community, economic and environmental restoration. The one big thing that's being forgotten is the mental health, after the event, of our firefighters. We all know about learning from our experiences—and I'm not talking about one month or even five years; sometimes I'm talking about 10 years. And I'm sure you've probably heard that over and over again through this inquiry. Sometimes the experience never leaves you, and you must develop a new life and a new normal.

Yet you get through the fires, and that's when our journey begins. I remember very clearly describing how my bucket was full to overflowing after 2003 here in the ACT, where I did hold quite a few leadership roles, and I'm sure you've heard a lot. I've read a few of the submissions, and they talk about the emotional bucket overflowing, and I have put there something that I went through with my emotional bucket. You just can't control it, basically.

I want to just skip to the second recommendation. This is one that I'm very passionate about. In 2004, after the 2003 fires, there was a report for the Council of Australian Governments. There was a COAG report that was put together. It was a national inquiry on bushfire mitigation and management. I strongly recommend you have a look at the recommendations in there. It doesn't necessarily delve into mental health, but what it does do is give you a bit of context. The inquiry was unconvinced that the public interest is best served by coronial investigations inquiring into operational decisions that are not directly related to deaths. This is critical because even I had to address 13 separate inquiries in the ACT afterwards. I wasn't involved in all of them, but I was certainly involved with people that were presenting and having to provide paperwork—with the training and all sorts of things. In this document they had a vision for bushfires in Australia for 2020—jeez, that's two years away!—where they talk about the research, risk, readiness, response and, most importantly, recovery. I suggest in the strongest possible terms that you go back and revisit that COAG national inquiry and adopt some of the recommendations into the

coronial inquiry. This is a leading factor for mental health issues after an event. I won't go through what the recommendations state, but I will tell you that, as a volunteer, you're reading the book.

Angela, who was from Port Lincoln and was the incident controller in 2005 who led that fire, handed over at 8.30 that morning when the fire was benign. By I think it was 11.30 that day nine people had died. As a volunteer, though, she was put on the stand for seven days. She was accountable to that coronial investigation for seven days. And the trauma, within itself, was only just the beginning. The coroner decided in his wisdom he didn't like going from Adelaide over to Port Lincoln, so he took the coronial investigation back to Adelaide. So, not only was she on the stand for seven days, she also had to be ripped out of her community, her brigade, her family and her support network. This had huge, huge consequences. I was actually mentoring Angela through this whole process, because I had been through it myself.

Now I'm not saying don't take fires out of the context of the coronial. What I'm saying is the operational component needs to be taken out, because, inherently, when you are in a court of law there has to be someone to blame. Unfortunately, with fires, there's not always someone to blame, and this is a critical component. The other thing is that coronial investigations can take two to three years. That means we're running under the old structure for two to three years, so, if there are improvements or mistakes or whatever, we have to wait until that process is finalised before we can go back and make changes. We can make changes, but the problem is they may not be the changes that are recommended at the end of the coronial investigation. So, in terms of the operational component, I strongly recommend you investigate that.

The third recommendation is that a place to speak openly and honestly needs to be set up to allow all teams and individuals to talk about their stories and share their experiences not only to assist in our understanding of the event but for people to realise that they're not alone. One of the big things I found with the book is that it helped people put the jigsaw puzzle together because, when you're on a massive fire like the one here in 2003, you're working over here or you're working over here and you don't know what's going on around you. Inherently, when you come back, you have to understand what's going on. You have that burning desire to make that full story. I was shocked when I was over in London recently visiting a friend who is a firefighter and was involved with the Grenfell Tower fire. I was asking how the firefighters were going, and he basically said they were told to shut up because of the investigations that were going on. I said, 'You can't do that.' I met a psychologist once who explained to me that when someone goes through trauma they have to tell their story at least 25 times before it starts to lose its grip. That's all trauma; it's not just our trauma. I just can't emphasise that enough. We need a space where we can go and talk and share our stories and they're not going to be taken out of context, not chucked in the coronial inquiry and not up there for evidence. We need that space to aid our recovery.

The fourth recommendation is a system that recognises the work undertaken in incredibly difficult circumstances instead of the blame game. We need to recognise the team effort that was required for a fire. I know from speaking to Angela after the Port Lincoln fire, when she was on the stand, that when you work on a fire you have to have teamwork. You have no choice but to rely on that teamwork. You work together, you have to have faith and you have to believe in each other. You have to believe what information you're given is correct, because that's what you base your decisions on. That's where our training and our teamwork come in. When you take that away, it can be very debilitating.

I remember my final submission that went to the coronial inquiry in 2003, to Coroner Doogan. I pleaded with her not just to look at the bad things and the things that they believed went wrong but to recognise the good things that we did. The one thing all the firefighters kept on saying after 2003 is, 'We can't believe we didn't lose anyone, although we had people injured, in the firefighting force.' I'm not talking about the public or the community. Don't get me wrong; it's devastating. But, when the blame game comes, you feel, 'Why did I do that? I'm not to blame.' I've never known a firefighter to this day that's gone to work to do a bad job, but that's how you end up feeling. So we need that recognition, I think, when it comes to investigations. It's important to recognise the good as well as the things that we can improve and the things that we can do better.

I remember clearly that one of the captains went to the head of ESA at the time and said, 'Look, I really just want you to get the captains together, go to a pub somewhere, just sit down and have a drink and a good steak and have a bit of a chat, but really we want to hear "thank you".' It's like what you were talking about before with the chief of the Ambulance Service about his apology. A lot of volunteers don't want remuneration. They don't want money. They do it because of the goodness of their heart. They want to contribute to their community, and they want to be part of a team. Most of the time, all they want is that recognition, and we don't get that a lot of the time through these inquiries.

The fifth recommendation is a process within fire agencies to be able to assist volunteers caught up in the coronial process and to explain and clarify the nature of what is happening for their employers—I'm talking about

in the private sector—and how they may be affected. It is mentally devastating when you are a volunteer and your day job has a lack of understanding of the trauma that you may be experiencing or the commitment that you have no choice but to contribute to. Again I'll use Angela as an example. She was on the stand for seven days. Her employer at the time was trying to make her take personal leave to attend a coronial investigation that she had no choice but to attend on behalf of that fire service. So it developed to the point where the coroner was going to get the police to issue an arrest warrant for her so she could attend the coronial investigation. You shouldn't have to go through that.

So this is what I'm advocating for. When you are in the private sector and a volunteer, we accept that we have to do this. We accept that we have to give evidence and be a part of these processes. What we're asking for is that someone then comes in and helps that private employee understand what that person's going through and helps them understand the commitment they have no choice but to give, so they don't end up with the mental stress and the torture of trying to fit in with your work environment, your day-to-day job and also your volunteer commitment.

Families are often overlooked in allowing them to help those who are closest to them. We become focused on the job and sometimes our family feel quite neglected. They don't always understand the trauma that we face and how it manifests itself. We withdraw and gravitate to those who shared the experience. We believe that families need to be included in the recovery process at the macro and the micro level. I can't tell you how many parents have actually bought this book when they've got a child who's been through quite a few different experiences—major fires, quick-moving fires and all that sort of stuff. They've sent me private messages and said to me: 'Vivien, now I know what my child is going through. Now I know how to help them.' There's the lack of understanding from the family's perspective as well—trying to understand what we're going through. I was very fortunate that my partner was also a firefighter and he was involved in the same fires. I can tell you now that sometimes we were miles apart, but at other times we were building a wall around each other to protect each other. We had that intimate knowledge of what we were both doing, but not all families have that. I know a lot of families have severe guilt when they spent so much time, especially at large incidents. When the coronial investigations happened in 2003, they stopped on 18 January, at midnight. We were fighting that fire for another month afterwards until it was finally declared out. That's a month of work that we were away for. I was telling my ex-husband at the time to take my three children and get them away because they were never going to see their mum; take them on a holiday. We feel it's very important that there have to be some processes to allow the families to be involved in that as well because quite often you'll find—and people have talked about this in the book—that the divorce rate after a major incident increases, unfortunately.

The final one is that senior managers are saying they do not want to be involved in the incident controller role—the person who controls the incident—due to the high demands and the additional trauma they face at an event if something goes wrong. Support is critical at all levels of firefighting, including leadership, and I'm talking about right at the top and all the way down—all the people in the incident management team; the whole lot. This has been communicated to me. It's anecdotal evidence, but what I'm saying is that some senior managers have communicated this to me. They won't complete all the training that's required of them to be deemed competent to do these roles, because they really don't want to be put in those really hard positions where there are major fires and they are constantly being bombarded with coronial investigations—the stress and the trauma. What we're saying is the support needs to be at all levels. I always say that a fire doesn't discriminate when you're on the fireground, whether you're paid or not, and I don't think we should be discriminated against either. I'm not saying we are—it's probably a strong word—but, when you go to a fire, whether you're a fully paid firefighter or you're a volunteer firefighter, we experience the same fire. What we're asking for is the same access to the same things. I've got plenty of stories that I can share with you about where that has just not occurred.

ACTING CHAIR: Thank you very much, and thank you very much for what is clearly a significant passion of yours.

Ms Thomson: Yes.

ACTING CHAIR: It's very good to hear the voice of a volunteer and that of the firefighting community. It's great that you could be here today. I am conscious of time. Senator Patrick, did you want to ask a few questions?

Senator PATRICK: I'll explore perhaps a couple of things. Thank you for your testimony and the book. We took evidence in South Australia. The Country Fire Service there were almost a second cousin in terms of any improvements. You might have heard some of the evidence from the AFP Commissioner and the New South Wales Ambulance Service just before you appeared. It sounds like lots of progress is being made in that area. I'm sure you would consider that welcomed. Is it the case that the volunteer services simply aren't getting enough attention?

Ms Thomson: In some aspects, I would agree with that. I came in here and listened to the commissioner of the ACT Emergency Services Agency, because my background, realistically, is in the ACT—that's where the major bulk of my firefighting was. I wrote down notes while he was talking, and I was quite heartened to hear him talking about the welfare manager that they now have. I was thinking, 'Yes, yes, finally something's starting to happen.' That's an absolute positive. But, for me, it needs to go beyond that. When you are working in your role full time and you're paid to do that role, things are just automatically there. As a volunteer, they're not automatically there. Even through the coronial inquiry, we had to fight for legal representation and things like that. If it's automatic for this person, it should be automatic for that person. When you go to a fire event, it's not different for any person; everyone experiences that same fire and everyone experiences that same emergency. So all those aspects should be available. There are a lot of good things that are happening now, yes. I think that that's a very positive program and I'd like to see it keep going, and going further. I want it embedded into the volunteer organisations, and not just when you have a brigade meeting; I want the whole structure there at all times.

Senator PATRICK: I'm just trying to contrast between that full-time first responder organisation and what is no doubt a more problematic but perhaps underfunded volunteer service.

Ms Thomson: Quite often we have a lot of new, shiny trucks, but we've got to have people to go on those big, new, shiny trucks. As to the funding, I think that, if it's available, it should be available across the services. I know that's a lot harder. You're talking about first responders. Well, a lot of volunteers, especially in regional and rural areas, are the first responders.

Senator PATRICK: Sure. I wasn't differentiating; I was simply saying that the full-time players seem to be getting their act together.

Ms Thomson: A volunteer told me a story last week. This volunteer went through the 2003 ACT fires. He went through a very hard mental health time afterwards. He rebuilt himself, and he's going exceptionally well. He now works in the mental health field, and he's using his experiences to his advantage. He was telling me that he then went down to the fires in Victoria, in 2009. We lost a firefighter down there—every firefighter's worst nightmare—who was an urban firefighter, and it was quite devastating for everyone on that fireground. When the volunteers came back to Canberra, returning from the task force, the urban fire brigade had its processes already in place and set up, and that was fantastic. I'd watched it before; when I was working in the incident room for the Thredbo landslide, I watched it firsthand. The problem was, when the volunteers came back, they got taken into the room for the government or the EAP or the counsellor—whoever was there—and they just got given a card and told, 'If you have any questions, just ring me.' They just don't compare, but they experienced the same thing.

Senator PATRICK: Thank you very much.

Senator URQUHART: Thanks very much, Ms Thomson, for your comprehensive opening statement; it actually answered a number of the questions that I had. You've spent a number of years working with the ACT emergency services in your capacity as a volunteer, but also as a training manager. At that time, was specific mental health training offered to firefighters and volunteers?

Ms Thomson: We had a wellness program, and we talked about health and those sorts of things. I wouldn't say there was anything in depth. At the time of the fires, I was working for the parks service—I actually had a paid role that was part of that—and I can tell you that didn't work very well either. When I was asking for help, I'd go to see the counsellor, who was provided by government services, and they would be on the floor. I'd tell them my story in 20 minutes, and they would say, 'Oh my God, you're a superwoman,' and I would say: 'No, I'm not a superwoman; I'm suffering like everyone else. I need help and support, because I've got a lot of people from my leadership roles that need support, and I'm struggling to support myself, let alone anyone else.'

Senator URQUHART: That's where you talk about the specific trauma counsellors, so that they understand—

Ms Thomson: Trauma counselling, yes. I churned up and spat out three counsellors until I finally found someone external to my work environment who was able to help me.

Senator URQUHART: Yes. I think that has been a common thread through this inquiry: the need for specialist—

Ms Thomson: Yes, absolutely.

Senator URQUHART: counsellors in terms of first responders, because a lot of people talk to someone who doesn't understand.

Ms Thomson: They don't understand. You spend all your time explaining everything.

Senator URQUHART: Yes, and then you've got to relive it and relive it and relive it.

Ms Thomson: And then you end up supporting them from what you're telling them, and it's like, 'No, you're supposed to be helping me!'

Senator URQUHART: That recommendation is pretty loud and clear about that.

Ms Thomson: Yes.

Senator URQUHART: One of the questions I have is: what strategies and techniques have you seen that work well to prepare firefighters—well, perhaps maybe volunteers—both before a major traumatic event and then post that event?

Ms Thomson: It's having that understanding beforehand. Having that is so critical. That's part of the reason why I wrote the book—because, five years out, it was still all there, boiling and bubbling inside me, so I had to get it out. Then, once I realised it was out, what I found was that people who didn't understand were reading the book and thinking, 'Oh, my God, okay, now I understand,' and they could see it, and they could feel it. The other important thing was that people who were going through it could also feel that they weren't alone. So I found, inadvertently, when people started reading the book or reading the stories or sharing their stories, that that understanding about what can happen is out there, and you can share it. And people can then understand what you're going through, especially with families, as I've mentioned.

But having that inherent understanding beforehand I think is absolutely critical. I don't think we've done that well enough in the past. You can't say, 'Oh, you know you'll suffer from PTSD.' I'm not talking about PTSD; I'm just talking about trauma after the event. But there are lead-ups before an event happens that we can absolutely do. If you're the best person that you can be before an event, you're going to be the best person that you can be after the event. I think we need to work on our mental health a lot more beforehand so, when we get to an event and it's traumatic, we've got a much better understanding about what's going to happen to us, and we can see it, and then you can counteract it.

Senator URQUHART: You've been around for 31 years as a firefighter, mostly as a volunteer. From when you first came in, I presume it's changed a little bit for volunteers over those years.

Ms Thomson: Yes, it's changed a lot.

Senator URQUHART: So tell me what happens to volunteers now. Do they get some of that debriefing before they actually get out? You go along to your local fire brigade—I've got a volunteer service in my home town in Tassie. People just rock up. There's a bell, and they have a pager, I think, and it goes off, and they just leave whatever they're doing and go to the fire station.

Ms Thomson: Off you go, yes. It really depends. Every brigade's quite different, and it really depends on the person in the leadership team that's running that brigade.

Senator URQUHART: There's no standard sort of approach?

Ms Thomson: No, not really. I don't think so. There are programs there that they can tap into. Not all will do that. And, especially when you're getting out into the small rural areas, people don't necessarily have the time or the energy. If you go out to any of the rural areas, we're battling the drought at the moment. The last thing we want to talk about is mental health with fires. Christ, we're battling with our mental health with drought at the moment. But, having said that, I think we've got those programs where brigades quite often get together for training. That's where we need to be, and we need to have someone who's trained in that brigade, or someone who is a part of that brigade from the head office—or whatever the structure that they decide it is going to best fit—to actually talk about it. Everyone knows there are counsellors available in the rural fire services.

Senator URQUHART: But it's better to be equipped before.

Ms Thomson: Everyone knows that it's there for the families as well if need be. I've actually rung up on behalf of firefighters and said: 'This guy needs help. You must ring him now.' So it's there.

Senator URQUHART: Does that happen? Do they get a phone call or—

Ms Thomson: This one in particular was a very serious accident that happened down the road from my farm, and, yes, help was implemented for him.

Senator URQUHART: That's good. So it's that sort of peer stuff that's useful as well?

Ms Thomson: Yes. And the other thing is, I think, sharing stories. I'm quite happy to stand up in front of everyone and tell them. For a period of time, I did self-medicate after the fire. I'd go home and have three gin and tonics or a bottle of wine, because I was just like this the whole time. I didn't know how to cope. Learning those coping mechanisms before you get to that point is the critical component, I feel, for helping you when you're going through it. Ensuring that teamwork is in existence as well also helps you. I rang quite a few people in the

book to say that I was going to be here, and I'm thanking Pat for coming along today, because he's there to support me, because it brings up all these emotions, and all you want to do is push them all back down again. So it's that peer support pressure, openly talking about it and openly sharing our stories. It's nothing to be ashamed of. I document it all in the book. As they talked to me, that's how I put it in the book. I did not sanitise anything, because it defeats the purpose. I think the more we talk about it, the more we understand and the more we do beforehand, the better off we're going to be after the event.

Senator URQUHART: I think that's certainly the message that I've tried to ensure gets out, at least during this inquiry process—for people to actually feel comfortable about just talking about it, because I think that's a good start to being able to resolve some of the issues.

Ms Thomson: Yes, absolutely. If you ask me any question, I'll tell you straight.

Senator URQUHART: Okay. My final question is—

Senator PATRICK: You can't be a public servant, then!

Ms Thomson: I was, for 20 years.

Senator URQUHART: What about debriefing? We've heard very mixed reports about the value of debriefing, particularly if it's not done well. What's been your experience with debriefing?

Ms Thomson: Debriefing can work well if it's done properly. After 2003, I was asked to organise the operational debrief for my brigade. I said: 'What? I'm suffering too. I need to be debriefed as well.' So I got smart about it, and I actually went to the psychological government people that do that sort of stuff, and I sat down and had a very long conversation with them. I said, 'This is what we're suffering, this is what's wrong and this is what you're going to face.' We did a massive briefing before we actually got to the event. There were two that I had to run, because we couldn't do everyone all at once. The first one worked not so well, because the person that came in just really couldn't connect and couldn't understand what was happening. In the second one, the guy was very well connected. He understood everything I told him, he listened to everything I told him and it was brilliant. Everyone walked out of that room feeling a foot taller—that they were listened to. So, when you come to debriefs, it's not just about getting it out. The reason we do debriefs is partly to see what we can learn and what we can do better. So if you walk away from that just having, dare I say, a wank fest, it goes nowhere and it will do nothing.

Senator URQUHART: That'll come up in *Hansard*, you know? It'll be in the book.

Ms Thomson: Sorry.

Senator URQUHART: That's okay. I'm just letting you know.

Ms Thomson: You get what you see! It will go nowhere, and it doesn't help anyone. One thing that did help is a hot debrief. I don't know if anyone talked about that.

Senator URQUHART: No. What is that?

Ms Thomson: I've found that, if a hot debrief is done properly, it works really well. That's when you've got the four people in your truck and you're going back. The crew leader or whoever is the leader in the truck does a quick hot debrief on the way back to the station or, when they get to the station, they say, 'Okay, guys, we've got 10 minutes, and we're going to talk about what we just went through.' You can pull stuff out of it straightaway like that. That hot debrief tends to work quite well. I don't know if people use it anymore.

The other system that I used to use is that, when I was actually on the fireground, I'd be monitoring my crews all the time. You'd be able to pick out those that were in a little bit of a panic or a little bit unsure or very quiet and reserved. So I would just sort of keep an eye on all those people, and then I'd pick it up and actually pursue them later on. Quite often when I was giving a briefing, if there was someone there that I felt was sort of hanging in the back and wasn't quite sure, I'd pull them off to the side and have a private conversation with them. It's providing that space.

In terms of the debriefing, I think there are a lot of good things that can be done, but it just has to be done so that, when people come in and bare their soul, they know that the people are listening and they're going to take that away. If they don't, you won't get them to contribute again in the next phase.

Senator URQUHART: Great. Thank you.

ACTING CHAIR: Senator Molan, do you have any questions?

Senator MOLAN: No, I don't, thank you. I appreciate what you've done, and Pat actually ran me through a testing exercise at the end of my RFS down at Guises Creek. But, no, I don't have any questions. I understand the points you're making, and I've seen them on many, many occasions. Thank you very much.

Senator PATRICK: I might also point out that, when I did my Navy training, they put me into a compartment with a real fire. It is one of the scariest things you can do. So I acknowledge the great work you guys do.

Ms Thomson: Yes, it can be scary. It's funny. I gave a talk once to female firefighters and said, 'You're not brave unless you're scared.' That little bit of being scared—not being totally scared—actually keeps you safe, because you're constantly alert. Can I just leave you with a quick quote.

ACTING CHAIR: Certainly.

Ms Thomson: Pat can tell you where he got it from. I heard a quote the other day—this is out of his chapter—that summed up January 2003: 'Fire is a harsh teacher. It gives you the test first and the lesson afterwards.' That pretty much sums it up for us.

ACTING CHAIR: Thank you very much for appearing today. We really appreciate it. On that note, we will conclude today's proceedings of the committee's inquiry into the high rates of mental health conditions experienced by first responders, emergency service workers and volunteers. I thank all witnesses who have given evidence to the committee today. I also thank Broadcasting, Hansard and the secretariat.

Committee adjourned 17:40