Metropolitan Fire and Emergency Services Board (MFB)

A Review of the MFB Employee Support Program (ESP)

Final Report
December 2016
In 2015 and 2016 the emergency services sector was facing the issues of mental health and wellbeing with a greater awareness and urgency than ever before.

In the course of providing lifesaving services to the community, firefighters and other first responders see and experience things that can have an immediately obvious impact, or a hidden or ‘sleeper’ impact. This can affect broader mental health or wellbeing issues for some people, and has flow-on effects in homes and private lives.

The issue came to the fore in the most tragic way for MFB in late 2015 and early 2016 with the loss of three of our own within a short timeframe. MFB had already drafted a Mental Health and Wellbeing Plan, but these events prompted us to seek independent advice to ensure that what we had, and what we are planning, were enough.

The result is both encouraging and challenging. We have some good basics in place, but clearly there are significant systemic and cultural issues that we must now be brave enough to face, and to challenge our understanding of the norm.

MFB firefighters are amongst the best in the world. They have world class training, facilities, appliances and protective wear. They deserve to also have world class support for the mental and emotional toll of their job, not only on them personally but on their colleagues and, very importantly, their families.

Safety is our number one priority. It is also our number one challenge. And it is extremely clear that looking after the physical safety of firefighters is not enough. We have to provide a safe, supportive workplace as well if we are to achieve our purpose to deliver a world class fire and emergency service to Melbourne and Victorians.

The findings of this Report, as well as the Fire Services Review (2015), demonstrate that change is critical to the health of our organisation and the sector, no matter how challenging it may be at a cultural, organisational or personal level.

I want to thank Dr. Peter Cotton for his forthright insights into our plans, our needs, and our future. I thank all of those who participated as members of the Review team, and most especially those who have shared their experiences with the Review team over the past few months. It takes courage to share stories and experiences about the mental and emotional impacts they have experienced.

It is essential to also recognise some of the most important people of all – our families. They are the ones who most keenly feel the consequences of our struggle to deal with mental wellbeing in the workplace. The reward for our effort will be worth it. We'll have a better place to work - somewhere our people feel supported when they need it, and safe at all times. We will be healthier, because some of those unhealthy coping mechanisms will be something we manage and minimise. We'll have more resilience as first responders and better relationships at work and with our families, friends and loved ones.

Jim Higgins ASM
CEO
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A brief Review of internal mental health and wellbeing services (Employee Support Program - ESP) was initiated by MFB following three deaths by suicide of employees between December 2015 and February 2016. The Review sought to identify any service gaps and indications for improvement; assess the adequacy of the DRAFT MFB Mental Health and Wellbeing Plan; and benchmark the ESP against comparable employee support models.

The Review involved conducting semi-structured interviews with a representative sample of 65 employees and internal and external service providers; analysis of wellbeing check data from 220 employees across 31 groups; consultation with key external stakeholders and; a review of relevant policy documents, guidelines and research.

The Review found that, similar to other emergency services organisations, the range of employee mental health issues involves more than traumatic stress responses. Anxiety and Depression, grief and loss issues, relationship problems, fatigue and sleep issues and substance misuse are also common presenting issues. Suicide rates are thought to be generally higher in emergency service organisations compared with the general community. No indications were found that the MFB is any different from comparable services.

The Review found that MFB’s ESP service demand continues to grow and the ESP is consequently now under-resourced. There are some shortcomings, including a lack of documented policies and procedures. As a result, this Report concludes there is a need to increase full-time equivalent (FTE) clinical and peer support positions, as well as electronic software and other forms of resourcing.

Mental health stigma is a common barrier to help-seeking behaviour, and the particular form of stigma found to be dominant in the MFB is ‘self stigma’: denial and avoidance due to a perception of shame or a view that ‘I should be more robust and therefore should not need any help’. This Report recommends expanding existing mental health literacy (education and awareness) training by updating the content, including suicide awareness content, and reformulating the program into an organisation-wide coordinated strategy. This includes embedding mental health literacy content in all leadership training programs. Further, the Report concludes that this will be a critical overall initiative contributing to the goal of suicide prevention.

The Review found that there is a lack of organisational systems to track cumulative incident exposure and thus guide more proactive risk management and support initiatives, which will be critical to improving mental health and wellbeing outcomes. This was found to constitute a key occupational health and safety risk. Further, ESP initiatives are insufficiently matched to the organisational risk profile (eg. more wellbeing checks and conversations are needed at stations that undertake relatively higher levels of Emergency Medical Response (EMR)). Another key finding was that MFB has exceedingly poor occupational health and safety and workers compensation performance. Typical workforce health and risk management initiatives - such as fitness for duty assessments and a drug and alcohol testing regime - are absent, and there is a lack of structured injury management practices. The Report makes several recommendations around developing a system to track cumulative exposure and implementing fitness for duty assessments and drug and alcohol testing.

The Review identified significant cultural barriers to progressing the mental health and wellbeing agenda. Fire stations are effectively family-like tribal sub-cultures with negligible mobility. They are highly supportive but generally not inclusive. The consistent high level of local support can also unwittingly serve to hide occupational health and safety risk.

The Review heard numerous reports of bullying, harassment and exposure to other inappropriate behaviours. The Report concludes that MFB has an excessively high tolerance margin for poor behaviour and inconsistent management, or a lack of appropriate management, of behavioural issues. The extreme lack of workforce diversity also contributes to this situation. The Report makes a number of recommendations around increasing leader accountabilities and more effectively addressing behavioural issues.
The current VEOHRC review was considered by this Review to be a vital initiative that will contribute towards improving MFB mental health and wellbeing outcomes.

The broader industrial relations context and associated media coverage has been negatively impacting on employee morale. Reduced morale is associated with a risk for increased negative responses to operational incidents, and hence this is associated with increasing organisational risk.

Finally, the Report recommends progressing towards a more employee-lifecycle focus in health management. Currently a number of the organisational functions that impact here operate in silos. The Report recommends increasing front-end resilience training, expanding and systematically targeting wellbeing checks, upgrading injury management practices and considering options around career breaks, and introducing exit screening and retired peer support services.
1. Introduction

The mental health and wellbeing of Emergency Services personnel including those of the Metropolitan Fire and Emergency Services Board (MFB) have come under increased focus in the past few years. Organisations such as beyondblue have undertaken an audit of emergency services mental health programs (2014), and developed a good practice framework to assist with organisational change (2016). Further, many Australian emergency service organisations have struggled with an increasing number of mental health presentations and most seriously, deaths by suicide that have received extensive media coverage.

As noted in the Fire Services Review (2015), these issues are set within a landscape of significant changes, both within emergency services organisations (eg. changing technologies and demands on services) as well as within the communities they serve (eg. anti-social behaviours from the public towards first responders) and the global context of service delivery (eg. the effect of climate change on fire services). The complex interplay of these issues and increasing pressure they may have on individual and group wellbeing are potentially significant.

The MFB has range of clinical and support services, referred to as the Employee Support Program (ESP), which have recently been the focus of increased attention as the MFB has grappled with the death by suicide of three firefighters in a two month period (between December 2015 and February 2016). This was an unprecedented organisational loss and shocked the firefighting community. A MFB Mental Health and Wellbeing Plan was being drafted at the time of the third death and it was decided that an external subject matter expert should review this document, as well as the capacity of the ESP to respond to organisational risks and identify any service gaps or indications for improvements.

The DRAFT MFB Mental Health and Wellbeing Plan contains five key strategic objectives, with accompanying priority actions (see Appendix one). This document has an overarching ‘resilience across the lifespan’ theme, which aims to provide an appropriate mix of pro-active (eg. organisational mental health literacy and reducing mental health stigma initiatives) and reactive (eg. targeted services for cumulative PTSD) service delivery, across the lifespan of an MFB staff member, and inclusive of their immediate family.

While the DRAFT MFB Mental Health and Wellbeing Plan is reflective of the beyondblue (2016) good practice framework, there are concerns regarding organisational capacity to implement and review such a plan. Like many other emergency service organisations, MFB is dealing with organisational and cultural distress, as well as resourcing challenges in the mental health and wellbeing space. Therefore the overarching aim of this Report is to examine the mental health and wellbeing services currently offered by the MFB, explore how these could continue to proactively evolve, and what would be required as part of a continual quality improvement process.

1.1 The Employee Support Program (ESP) Review

The Board and Executive Leadership Team chose to appoint Dr. Peter Cotton, an independent workplace mental health expert, to lead the ESP Review and produce this Report. The purpose of the Review was to assess where the ESP currently sits in relation to national and international standards; the extent to which the ESP is effectively meets service demand; identify any service gaps and; make program recommendations.

The Review was intentionally shorter in duration and depth of consultation (as compared to other Reviews, such as that undertaken by Dr. Cotton recently with Victoria Police), as much of the framework and comparative analysis had already commenced within the ESP. Moreover, capacity for service delivery was deemed an immediate and time critical issue to be urgently addressed.
The Terms of Reference for the MFB Review of the ESP were as follows:

1. Assessment of current Employee Support Program (ESP) processes, policies, and procedures.
3. Assessment of the scope of support and professional supervision that is provided to the clinicians, professionals and internal peers who provide services to the MFB workforce.
4. Where possible, benchmark of ESP against comparable support models provided in similar emergency services and trauma-response organisations and service delivery settings.
5. Assist with the mapping of service and program pathways, including both internal and external service providers.
6. Make recommendations for ongoing evaluative processes of specific programs within Employee Support to help ensure optimal ongoing quality and effectiveness, including suggested resourcing.

Rather than specifically organising the Report's chapters around these Terms of Reference (ToR), the Review team requested and was supported to format the Report around key themes identified through the Review process, while still responding to the ToR throughout the body of this document. Appendix two details the key findings regarding the ToR and directs the reader to sections of the Report that unpack each component.

The ESP Review is proposed to underpin the continuing development and implementation of the DRAFT MFB Mental Health and Wellbeing Plan.

Throughout this document there are quotes from interviewees, which have been used to illustrate the lived experience of MFB staff and contracted employees. These quotes have been carefully chosen to reflect multiple reported experiences, and to not identify specific individuals without their express permission.
2. Methodology

The Review commenced in June 2016 and included conducting semi-structured interviews with a wide range of MFB staff, health and mental health experts, and other key stakeholders, as well as reviewing a number of data sources.

2.1 Interviewees

The review team conducted semi-structured interviews with:

- Firefighters
- MFB Peer Support Officers and past and current Peer Support Coordinators
- Contracted clinicians
- Chaplain
- Return to work and injury management staff
- Occupational Health and Safety staff and
- Senior managers

A total of 65 individuals were interviewed. Additionally, de-identified data was also included from approximately 220 people, collected during group 31 Wellbeing Checks (mental health and wellbeing screenings), between 31 May and 31 August 2016. All interviewees were assured of confidentiality.

The Review team also conducted an environmental scan and a brief literature review. Due to the tight timeframes, calling for submissions from key stakeholder groups was not considered to be viable.

2.2 External stakeholders

Key external stakeholders consulted included:

- beyondblue
- WorkSafe
- Gallager Bassett (workers compensation insurer)
- Brigade Medical Officers
- The United Firefighters Union

2.3 Key references

Key reference documents reviewed included:

- AFAC 2014
- beyondblue (2014): Audit of emergency services mental health programs – Summary Report
- beyondblue – Heads Up (2016): Good practice framework for mental health and wellbeing in first responder organisations
- Department of Defence (2012): Pathway to Change: Evolving Defence Culture
- DRAFT MFB Mental Health & Wellbeing Plan 2016 - 2018
- Government Response to the Report of the Victorian Fire Services Review
- Living Is For Everyone (2016)
• Mental Health Commission of Canada (2013): Psychological health and safety in the workplace – Prevention, promotion and guidance to staged implementation
• MFB Always Safe Action Plan 2015-2018
• MFB Annual Report 2014-2015
• MFB Plan 2016-2017
• MFB Wellbeing Checks document
• National Defence and the Canadian Armed Forces (2015): Road to Mental Readiness (R2MR)
• Phoenix Australia (2013): Australian guidelines for the Treatment of Acute Stress Disorder and Posttraumatic Stress Disorder
• University of Melbourne – Orygen Youth Health Research Centre (in conjunction with beyondblue) (2011): Helping employees successfully return to work following depression, anxiety or a related mental health problem: guidelines for organisations
• Victoria Police Mental Health Review (May 2016)
• WorkSafe, Vic Health & Super Friend: Victorian Workplace Mental Wellbeing Collaboration
3. MFB mental health profile

3.1 Key findings

- Post Traumatic Stress Disorder (PTSD) is not the only mental health risk within the MFB: other mental health issues (such as Depression, Anxiety, and substance use disorders), are prevalent and appear to be increasing.

- Work related distress (as distinct from trauma exposure during EMR and Critical Incidents) is having an increased effect on mental health and wellbeing.

- Suicide risk is difficult to accurately appraise, but is thought to be higher in Emergency Services generally than in the general population, and is of significant concern given the recent increase in deaths by suicide of MFB staff.

- The uptake and engagement of the organisation in mental health and wellbeing screening (the "Wellbeing Checks") has been significant and positive to date, and continues to expand.

- Issues of wellbeing (as opposed to mental ill-health/illness), as identified during Wellbeing Checks, indicate that areas of 'feeling respected' and 'having a sense of meaning and purpose in daily activities' present opportunities for organisational improvement.

3.2 MFB mental health and wellbeing issues

The mental health profile and mental health presentations within the MFB cannot be detailed with complete accuracy. As with many emergency services, concerns about workplace mental health surveying along with issues of stigma and delay/avoidance of help-seeking mean that any statistics need to be interpreted with caution. It is still possible however to examine statistics compiled from the MFB clinicians and the MFB external EAP provider, as well as de-identified general information obtained during the Wellbeing Checks, and to suggest that the number of people receiving support from these services is only a proportion of those who actually need such services.

The most commonly presenting issues are detailed in the table below. These are typically what are known as the primary presentation issues, meaning that these are the root cause of the person’s psychological distress. The secondary presenting issues, meaning those that are typically caused by the primary presenting issue, are almost always related to family/relationship issues and/or substance abuse issues.

The quote below exemplifies a typical way in which these issues present in the same individual:

"There are an untold number of fireys who are on their second, third or fourth marriage, who drink far too much and have never realised that all the trauma they have seen has played a huge part in how those issues came about in the first place".  

comment from a clinician
### Table 1: Primary clinical presentations

<table>
<thead>
<tr>
<th>Issue</th>
<th>Content</th>
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</thead>
<tbody>
<tr>
<td>PTSD/trauma related</td>
<td>Exposure to EMR and critical incidents (suicides, road fatalities, the death/serious injury of children) is leading to a rise in trauma symptomology. While these can present as PTSD, they may also present as “sub-syndromal” PTSD – that is, a person may be experiencing significant psychological distress but not technically meet the diagnostic criteria for PTSD. The EMR and critical incident exposure can also lead to clinical distress in the form of vicarious traumatisation, secondary traumatisation (which occurs when colleagues/Peer Support staff are supporting an employee who had the initial exposure), and clinical levels of occupational burnout.</td>
</tr>
<tr>
<td>Work stress</td>
<td>A multitude of compounding and correlated work stress issues have been noted, including distress caused by the protracted EBA negotiations, a lack of perceived organisational support, discontentment with organisational culture (including concerns about bullying and harassment), psychological distress caused by negative media and community attitudes towards the MFB, and distress regarding the apparent divide between the corporate/senior management and operational staff.</td>
</tr>
<tr>
<td>Anxiety and Depression</td>
<td>Presentations of high prevalence disorders (Anxiety and Depression) tend to have a range of causal factors. Some of these can relate to the earlier issues of trauma exposure and work related stress. However other issues including relationship difficulties (primarily marriage and/or family relationships), financial hardship and physical health issues can contribute to the development of Anxiety and Depression.</td>
</tr>
<tr>
<td>Grief and loss</td>
<td>A multitude of grief and loss issues have been noted to be causing clinically significant distress. These have included the effects of the deaths by suicide of four firefighters in the past two years. Grief and loss is also a significant issue for the ageing workforce as their parents become incapacitated and eventually die and as staff prepare for retirement. There is also significant grief and loss associated with relationship and family break downs.</td>
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### Table 2: Secondary clinical presentations

<table>
<thead>
<tr>
<th>Issue</th>
<th>Content</th>
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<tbody>
<tr>
<td>Relationship issues</td>
<td>While relationship issues can be a primary presenting issue, they are often seen as consequences of other mental health and wellbeing concerns, noticeably with regard to PTSD/trauma exposure and work stress. The results of this have included relationship distress and breakdowns, which have formed a noticeable body of work for the external EAP provider (whose counselling services are more likely to be taken up by family members of MFB staff). Relationship issues are also being highlighted within the organisation, again as a potential result of work stress. Specific issues of bullying and harassment, concerns regarding an absence of workplace civility and broader organisational distress regarding perceived lack of organisational respect and support have been significant.</td>
</tr>
<tr>
<td>Fatigue and sleep issues</td>
<td>The majority of the MFB workforce are operational staff who perform full time day and night shifts, and the Review Team noted that a significant number of staff reported fatigue and sleep deprivation related to this work (in particular those that have “cas jobs” – a second job on their days off, or commitments to young children/ family members). Sleep deprivation can have a compounding effect on primary presenting issues and lead to a state of significant cognitive impairment if not adequately managed. Research indicates that sleep deprivation is comparable in effect to alcohol intoxication with being awake for 17 hours being equivalent to a Blood Alcohol Concentration (BAC) of 0.05. Twenty four hours awake is equivalent to 0.1 BAC (Williamson &amp; Feyer, 2000; Druginfo Clearinghouse, 2010). This has significance in relation to the potential effects for reduced motor coordination and reduced concentration, which may be playing a part in the MFB’s avoidable accident profile. Dr. Gilmartin (2002) also describes a broad range of detrimental effects of shift work including breaking down the protective factor of social connectedness, which has anecdotally been related to relationship breakdowns (mentioned above, in “relationship issues”).</td>
</tr>
<tr>
<td>Substance misuse</td>
<td>Alcohol and other drug misuse is of significance in emergency services organisations. While it can sometimes be the primary presenting issue, as with relationship concerns it is just as likely to be a secondary response to a primary issue related to significant mental health issues (eg. PTSD, Depression and/or Anxiety). The absence of a coordinated and comprehensive response and treatment plan means that substance abuse also represents an unexplored area of organisational risk for the MFB.</td>
</tr>
</tbody>
</table>
The Review team noted that, similar to findings within the Victoria Police Mental Health Review, the range of clinical and psychological distress within the MFB is not solely related to PTSD presentations. While this does appear to be an emerging and significant presentation in its own right, to focus primarily on PTSD at the expense of other high prevalence disorders and concerns would be counter-productive. The Review team is aware that the Austin Hospital is trialling an individual outpatient PTSD program for Victorian firefighters, which current MFB firefighters are able to attend. As this program was normally offered on a group basis, which the Review team heard could result in a significant lag time between presentation for treatment and treatment commencement, this could be of significant benefit to interested participants. This pilot is limited to 60 Victorian firefighters and spread over two years, meaning that findings may be available after October 2018.

3.3 Suicide

A recent systematic review and meta-analysis by Witt and colleagues (from Deakin University, and currently submitted for publication) found that "rates of suicide in protective and emergency services workers are significantly higher than corresponding rates in members of the general working population". This is despite the fact that emergency services organisations screen for mental health issues during recruitment, and therefore theoretically only allow mentally healthy individuals to enter the service (this is known as the "healthy worker" effect).

In general, the suicide rates of firefighters tend to be lower than those of police or ambulance service members. The National Coronial Investigation System data from 2015 demonstrated that from July 2000 to December 2012 there were 110 deaths by suicide of Emergency Services personnel; 62 police, 22 firefighters and 26 ambulance service members. Data cannot be broken down in great detail for Australian firefighters, but NSW had the highest number of those deaths (ten), followed by Victoria (five). Overwhelmingly, these firefighter deaths occurred among males (95.5%) aged between 30-49 (77.3%) in whom about two thirds (63.6%) had been noted to have a history of psychological distress.

In the MFB there have been four deaths by suicide since December 2015, three of which occurred in a two-month period (December 2015 – February 2016). All of those were males aged between 35-60. This fits with suicide data in the general Australian population, where the suicide rates peak amongst males aged 40-54 (ABS (2016), Causes of Death, Australia 2014). However, this represents a significant spike for MFB.

The causes of suicide are always multi-factorial; this means that a combination of risk factors may be present, and the mix may vary in different individual situations. Risk factors include: experiencing a mental health issue, particularly Depression; the breakdown or loss of a significant relationship, traumatic experiences and/or severe life stresses that seriously affect wellbeing; personal background vulnerabilities; previous suicide attempts (or being affected by the suicide of another person); substance abuse (especially alcohol); financial concerns; a sense of helplessness and hopelessness; poor physical health, poor self-esteem (often containing a sense of guilt, shame or blame); perceived lack of support/social connectedness; living in a rural location and; having an Indigenous background (ABS (2016), Causes of Death, Australia (2014); beyondblue – the facts - suicide).

Many risk factors for suicide are not work related. Some work factors can potentially be directly or indirectly linked, including the cumulative effects of incident exposure, effects of shift work on relationships and family life and lack of access to flexible working hours. In an occupational health and safety sense, the risk of incident exposure in frontline fire and emergency services can never fully be mitigated because of the very nature of the work involved. Hence, beyond risk mitigation is the need to invest in building workplace protective factors such as supportive leadership and positive, inclusive and engaging workgroup environments. Further, suicide prevention is improved through building organisational mental health literacy (ie. awareness
and recognition of early warning signs), reducing mental health stigma and validation of early help-seeking behaviour and; proactively initiating supportive wellbeing conversations with individuals who are not behaving as they usually do. This includes leaders at all levels fostering a climate that is supportive of wellbeing and role modelling reaching out to at-risk employees (as a people leader and not becoming quasi counsellors or diagnosticians). These issues are discussed further in chapter five.

3.4 Recommendations

1. There is a need for more accurate prevalence data to establish a baseline profile to clarify the precise extent of mental health (including substance use/abuse) and suicide risk. Such prevalence data could also be used to fine-tune future mental health and wellbeing initiatives, as well as evaluate the effectiveness of the mental health strategy. Therefore, the MFB’s active participation in the beyondblue national prevalence study (to be implemented in early 2017) regarding emergency services mental health is recommended.

2. Mental health literacy initiatives (including Mental Health First Aid and suicide awareness training, as well of issues of trauma, vicarious trauma, burnout and cognitive impairment) should be prioritised for MFB staff in key leadership, managerial, and occupational areas. This will be discussed further in chapter five, along with resourcing recommendations for the ESP to deliver this service in chapter four.

3. It is also recommended that the MFB develop a cumulative suicide register and undertake ‘psychological post mortems’ after the death by suicide of MFB staff (as practiced by Victoria Police and other agencies) to build organisational knowledge and help identify any common risk factors. This process essentially involves a clinical analysis to identify risk and causal factors associated with within the deaths by suicide, and implementation of learnings to attempt to negate future risk. While obviously a reactive measure, this allows for the reflection and implementation of any best practice issues not currently being enacted (as per the National Suicide Prevention Strategy, Living Is For Everyone, 2016).
4. Current ESP service profile

4.1 Key findings

- Overall the ESP is well regarded within the organisation.
- The current developmental initiatives produced by the ESP create the potential for achieving best practice.
- The Review team identified a number of current shortcomings that need to be addressed to implement the developmental initiatives.
- Resourcing to deliver ESP is outdated and is based on a narrower scope of service delivery and a historically lower level of demand.
- Inadequate documentation relating to service delivery and data capture for service planning was noted.

4.2 Current ESP staffing

In its current structure, the MFB Employee Support Program has a small number of full time employees and a much larger group of Peer Support Officers (who provide collegial support in a voluntary capacity). Those roles are:

Table 2: Current ESP Staffing

<table>
<thead>
<tr>
<th>Issue</th>
<th>Content</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee Assistance Coordinator (1.0 FTE)</td>
<td>Provides strategic planning and program oversight, as well as support for the Peer Support Program. Also heavily involved in training and education, Wellbeing Checks, critical incident responses/planning, and triaging into clinical support services (the EAP and/or MFB clinicians).</td>
</tr>
<tr>
<td>Peer Support Coordinator (1.0 FTE)</td>
<td>Provides oversight and management directive for the Peer Support Program, and well as the Critical Incident Response system. Also heavily involved in training and education and organisational support practices.</td>
</tr>
<tr>
<td>&quot;MFB clinicians&quot; (equivalent to 1.2 FTE) NB: These are contracted clinicians, as opposed to MFB employees</td>
<td>Provision of specialist counselling services, Wellbeing Checks and secondary or tertiary support for the Critical Incident Response system. This represents a clinician to staff ratio of 1:1833.</td>
</tr>
<tr>
<td>MFB Chaplain (0.5 FTE)</td>
<td>Provides spiritual and pastoral support for MFB staff and their families, and plays a significant role in grief and loss situations (including funerals).</td>
</tr>
</tbody>
</table>
Table 2: Current ESP Staffing (continued)

<table>
<thead>
<tr>
<th>Issue</th>
<th>Content</th>
</tr>
</thead>
</table>
| MFB Peer Support Officers (approximately 80 voluntary MFB staff members, who perform their Peer role outside of their normal duties) | Provide general support and assistance to MFB staff and their families, as well as assist with education and training, the Critical Incident Response system, and referral onto specialist clinical services.  
This represents a Peer to staff ratio of 1:28. |
| Employee Assistance Program                                           | Contracted external provider offers general counselling services for MFB staff and their immediate families. Also offers a 24/7 Crisis Hotline as well as a Manager Support line. Access can occur directly (via a 1300 number), or can be triaged via the Employee Assistance Coordinator. |

4.3 Current ESP usage

The Review team heard that the use of the Peer Support Program has grown substantially since its inception, with noted increases occurring after the three recent deaths by suicide. However actual statistics regarding the use of the Peer Support Program were noted to be problematic. The Review Team found that it was widely understood that “Peer stats” were not always documented and thus did not provide an accurate reflection of service delivery. This issue is not uncommon across organisations with Peer Support Programs. The Review team notes that this could be improved within the MFB through the use of electronic data collection methods (as opposed to paper and then internal mail-based processes). This will increase the ability of the Peer Support Coordinator to oversee Peer service delivery. It is also crucial to keep reminding Peers about the reasons that their “stats” are important: The Review team recommended that the ESP find ways to regularly communicate back to the Peers regarding the key findings (eg. trends, increase/decrease in numbers, how these figures are being used by management etc.).

Statistics regarding the use of clinical services have only recently been compiled (December 2015 onwards) however it is possible to observe an increase in the uptake of internal clinical counselling based on invoices from the clinicians. The table on the next page demonstrates an example of the rise in the number of clinical hours of service delivery:

### Contracted external clinicians: reflection on first half of 2016

NB: this clinician data is made up of two clinicians work, at approximately 1.2 FTE.

<table>
<thead>
<tr>
<th>Topic</th>
<th>1 January – 31 March 2016</th>
<th>1 April – 30 June 2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total number of client cases</td>
<td>74 clients</td>
<td>90 clients</td>
</tr>
<tr>
<td>Total number of hours of service</td>
<td>238 hours</td>
<td>355 hours</td>
</tr>
<tr>
<td>Average number of hours per client during this quarter</td>
<td>3.22 hours</td>
<td>3.94</td>
</tr>
<tr>
<td>Primary presenting issues – Top 5</td>
<td>Work Stress – 18.3%</td>
<td>PTSD/trauma – 26.5%</td>
</tr>
<tr>
<td></td>
<td>PTSD/trauma – 13.9%</td>
<td>Work Stress – 18.3%</td>
</tr>
<tr>
<td></td>
<td>Anxiety – 13.3%</td>
<td>Anxiety – 13.1%</td>
</tr>
<tr>
<td></td>
<td>Grief and Loss – 12.7%</td>
<td>Depression – 12.2%</td>
</tr>
<tr>
<td></td>
<td>Depression – 12.0%</td>
<td>Grief and Loss – 8.7%</td>
</tr>
<tr>
<td></td>
<td>(Other: 29.8%)</td>
<td>(Other: 21.2%)</td>
</tr>
</tbody>
</table>
4.4 ESP service delivery

The Review team found that, overall, the Employee Support Program is well regarded within MFB. There are no major gaps in the service itself, however there are significant demands placed on available staff, especially the Peer Support Coordinator and the Employee Assistance Coordinator. The requirement for these two roles to play a significant part in organisational training, mental health screening, triaging of clinical referrals and responding to critical incidents has meant that MFB has needed to purchase additional supports from the contracted clinicians to respond to these increasing needs. Accordingly, costs for subcontracting external clinicians have increased by almost 150% since 2012. The use of subcontracted clinicians however is noted to be a reactive service strategy and does not allow for good strategic planning or proactive service delivery. The Fire Services Review (2015, p. 25) suggests that greater resiliency is built into an organisation when flexibility is “built into the system by training slightly more people than required to meet minimum need for specialist skills”. This allows for continuity of business by factoring in leave provisions and periodic additional demands created by unforeseen circumstances.

Referrals to the EAP service, the Chaplain, and/or the subcontracted clinicians can come through a number of pathways. The most commonly utilised methods appear to either be self-referral or an assisted referral through a Peer Support Officer. Other options include the Employee Assistance Coordinator triaging and making a referral to a specific clinician (either an MFB or EAP clinician), the Brigade Medical Service and line management. There is no formal referral paperwork or record keeping regarding the referral process, apart from the Peer Support Officer Contact Sheet having a tick box option to indicate if a referral was offered to the staff member. The day-to-day practicalities of this method of data collection mean that accurate referral statistics are not available, along with high levels of confidence in the accuracy of organisational data regarding trends in Peer Support services.

The Review team noted that documents relating to policies and procedures do exist for the ESP, however due to time constraints on ESP staff they have not been appropriately reviewed or updated since 2009. While the majority of the contents in the Employee Support Program - Protocols and Operations Manual for Peers and Coordinators (2009) are essentially in line with best practice, many details need to be updated and some processes further clarified and adapted to be more realistic (eg. the expectation that the Employee Assistance Coordinator is “on call 24 hours a day to provide crisis counselling/trauma intervention services to the Board and all MFB staff”, as detailed on p. 13). In some cases what is contained within the document is not actually occurring, again because of staffing and resourcing constraints (eg. the requirement that “Peer Support officers undertake at least two sessions of supervision per annum”, as detailed on p. 12). For this document to have any genuine application to the ESP it therefore needs to be completely refreshed.

4.5 ESP Critical Incident Response

A significant service area for the Employee Support Program, in particular the Peer Support Coordinator and senior Peers, is the management of the Critical Incident Stress pager. This is a 24/7 pager service that responds to any MFB critical incidents (with critical incidents being defined as incidents such as the death or serious injury of an MFB staff member, firefighters attending a scene where there has been a death by suicide, death/injury to a child, road fatality, or death by fire). The activation of this pager can result in a range of activities, including contacting the crews who were present at the Critical Incident scene, organising a station visit, and activating clinical support services for affected individuals. While there are no current concerns about the delivery of this service, there are significant concerns regarding the fact that there is no adequate way to confidentially plan and document this service response. This leaves MFB open to operational and organisational risk issues, as the critical incident management process cannot be accurately tracked or reviewed and the risks
of secondary/vicarious traumatisation to activated Peers and staff is not being recorded or monitored. Overall, the service response to critical incidents is ad hoc and based on individuals and their preference for documentation and management. An externally hosted critical incident database, along the lines of that developed by either the Tasmania or Queensland Fire and Emergency Services, could be adapted to service this need and would make significant inroads into managing these risks.

The Review team noted that the amount of work associated with managing the critical incident pager can cause distress to the Peers, both in terms of volume of work and the nature of the work. The Review team has heard of occasions where Peers have, in moments of frustration/exhaustion, requested to "hand back the Pager and preferably never see it again" (comment from a senior Peer). There is also unchartered risk with this service for the Peer Support Coordinator, who is responsible for answering the Pager for up to 96 straight hours, as well as function within the Peer Support Coordinator role providing 'business as usual' services. Concerns around this risk form part of the recommendation for having a second full-time Peer Support Coordinator, as well as a clinician capable of providing supervision services (see the accompanying Business Case, as well as the remainder of this chapter for further information).

4.6 Peer Support program

The Review team found that, overall, the Peer Support Program also has good organisational buy-in and regard and is generally consistent with best practice Peer Support frameworks (Creamer et al, 2012). Peers provide a significant body of support in the prevention/early intervention space, and as such can be seen as the front line mechanism for delivering mental health and wellbeing initiatives; hence an organisational investment in this process is strongly recommended, as per the recommendations in the beyondblue (2016) guidelines.

The MFB Peer Support program has grown significantly over the years, with numbers developing from around 40 staff in 2011 to 80+ Peers in 2016, with goals to increase this number to around 120 in the next two-three years (thus creating a Peer to staff ratio of 1:20, which aligns with the strategic service provision planning to be able to deliver 'whole of organisation' prevention and early intervention practices). Clinical support and supervision for the Peers has traditionally been provided by the Employee Assistance Coordinator. Initially, the model was designed for approximately 40 peers. Currently with 80+ peers, the capacity of the EAC and Peer Coordinator to engage with every Peer member has become untenable, even though attending two sessions per annum of clinical supervision is a part of the MOU for all Peer Support Officers. This is a current organisational risk both in terms of monitoring the quality of Peer Support and monitoring the wellbeing of Peers as they provide their services. Concerns around this risk form part of the recommendation for having a second full-time Peer Support Coordinator, as well as a clinician capable of providing supervision services (see the accompanying Business Case, as well as the remainder of this chapter for further information).

The Review team found that MFB Peers were generally satisfied with their Peer role, however additional resourcing (such as apps and handouts), regular clinical supervision and greater support with the critical incident response would assist them in feeling more confident and supported in their role. In particular, regular clinical supervision could assist in the monitoring and preventing of burnout and vicarious traumatisation.

4.7 External Employee Assistance Provider (EAP) service

There was mixed feedback regarding the external EAP service, with concerns regarding the clinician's capacity to understand and treat complex trauma being an ongoing concern, which is not dissimilar to concerns noted by other emergency service organisations. Other concerns noted included: poor clinical care from clinicians; poor administrative service when contacting the general 1300 number and; poor general knowledge of the business of MFB.
The Review team heard that comparisons had been made between different emergency services practices with regards to EAP, for example the Queensland Public Safety model of having a service agreement with a large number of subcontracted clinicians (effectively creating their own EAP ‘group’). On reflection, the Review team believes that, unless such a project was shared across a group of Victorian emergency service organisations, such a service model would be costly and difficult to establish and manage. In the absence of any additional suggestions, the Review team therefore recommends that MFB continue to have a range of internal (contracted specialist clinicians) as well as external (EAP) providers. This is in line with the beyondblue Good practice framework (2016), which noted that having multiple methods of seeking and receiving support appears to best fit the needs of emergency service organisations. Further, an external EAP service is an efficient method of providing EAP support to family members. The Review team noted that the EAC has taken on a ‘triaging and referral role’ into the EAP provider. This is similar to what is occurring in other emergency services (eg. Victoria Police), and anecdotally appears to provide a better link between MFB and individual external clinicians.

However the Review team noted that this can form a significant body of work for the EAC, and hence recommendations about further resourcing the ESP as well as allowing the EAC to go ‘off line’ to focus on strategy are made within this chapter.

4.8 Service comparisons

Given the nature of MFB’s work (specifically the combination of both fire and emergency services as well as EMR delivery) it is difficult to make meaningful comparisons with other Australian fire services. In some respects, MFB’s mental health risks and exposure profile have more in common with the Police and Ambulance profile.

MFB currently has an approximate Peer to staff ratio of 1:28 and a clinician to staff ratio of 1:833. Some brief comparative data is listed below:

- **Victoria Police** has a current approximate Peer to staff ratio of 1:30, with plans to reduce this to 1:17. Its clinician to staff ratio is currently 1:1636, with a recent leadership commitment to increase this to 1:818 (a doubling of the number of internal clinicians).

- **Ambulance Victoria** has a current approximate Peer to staff ratio of 1:42, and an internal clinician to staff ratio of 1:2000 (with a review of this arrangement planned for its own upcoming Mental Health Services Review).

- **NSW Fire and Rescue** has a current approximate Peer to staff ratio of 1:84, which it will be reportedly improving on in the near future. Its internal clinician to staff ratio is currently 1:1200, with plans to increase this to 1:900 (an increase of 25% in contracted clinician hours).

- **South Australian Metropolitan Fire Service** has a current approximate Peer to staff ratio of 1:17, with plans to increase this to have a Peer Support Officer at every station. While it doesn’t have any internal clinicians, it has a long-standing arrangement with a boutique EAP service that is able to cater for its specialist needs, and has approximately 12 clinicians on staff.

- **Queensland Public Safety** (which includes the fire and state emergency services) has a current approximate Peer to staff ratio of 1:250. However it also has a specialist clinician arrangement, which has allowed for the subcontracting of approximately 103 clinicians across the state, giving a clinician to staff ratio of 1:383.

These figures are noted as being approximate, in particular for Peer Support Officers, as at any given stage a Peer Support officer may be “on sabbatical” – that is, not currently active in the program, but not departed from the program.

Overall, these figures would suggest that MFB has a good Peer to staff ratio but could improve in the area of either contracted or internal clinician resourcing.
As discussed earlier however, the reliance on subcontracted clinicians does not allow for good strategic planning or proactive service delivery, as it is primarily a reactive service response (eg. if more clinicians are subcontracted to provide wellbeing checks, this is only responding to the current service demand for the checks, rather than building ESP capacity for the best practice to deliver the checks). If there were additional clinicians within MFB, a model of internal Clinical Group Supervision combined with external individual supervision (as per the disciplinary requirements of the individual clinician) would best meet their supervision needs.

The Review team has been informed that, since the release of the Victoria Police Mental Health Report, there has been an approximate increase in service demand of 60%. This appears to be primarily made up of people who are seeking support because of positive publicity surrounding the Victoria Police Report, as opposed to "new" mental health concerns. The Review team notes that this is a positive step, as earlier intervention is more effective from both a psychological recovery as well as an organisational cost perspective. However, the implications of this rise in service demand need to be considered by MFB with regards to staffing and resourcing the Employee Support Program.

4.9 Strategic snapshot and 'best practice' reflections

The Employee Support Program has been working on a strategic action plan, the DRAFT MFB Mental Health and Wellbeing Plan 2016-2018. The Review team found that this document is consistent with best national and international practice, including the beyondblue Good practice framework (2016). The focus on 'resilience across the lifespan' is central to this action plan, which is echoed nationally (eg. the Australian Defence Force Mental Health and Wellbeing Strategy, which focuses on Resilience and Mental Fitness) and internationally (eg. the National Defence and the Canadian Armed Forces – Road to Mental Readiness), and is stressed within the Fire Services Review (2015 p.3) where it states, "support must be provided as a part of an overall, whole-of-working-life regime". The Plan also recognises that, due to the demands of emergency services work, MFB must increasingly acknowledge the importance of families and continue to support members and their families after the transition to retirement. The Review team notes that, once the final version of this Report has been released, the DRAFT MFB Mental Health and Wellbeing Plan will need revision to include the final Report recommendations. As acknowledged earlier, this will require the EAC to go 'off line' from other areas of direct service delivery.

Having a greater commitment to developing and implementing a Mental Health and Wellbeing Plan would allow for proactive service planning and delivery that exemplifies industry best practice to advance out of current reactive models of care. The pressure to adopt such an approach is mounting beyond recommendations in the Fire Services Review (2015) through recent publications such as beyondblue Good practice framework (2016), the Australian Defence Force’s Mental Health and Wellbeing Plan (2012 - 2015), the University of New South Wales/Black Dog framework for clinical PTSD service delivery (2014) and the Department of Defence (Pathway to Change: Evolving Defence Culture, 2012).

In a large organisation such as MFB, beyondblue’s organisational arm ‘Heads Up’ research findings state that a comprehensive and well-conceived Mental Health and Wellbeing strategy may achieve a “33% reduction in absenteeism, presenteeism (being at work, but not being productive) and compensation claims”. The investment required to work towards implementing a comprehensive and well-conceived Mental Health and Wellbeing strategy would be a fraction of the cost of potential savings. Simply from a financial perspective, the implications are substantial. For instance, a 33% reduction to WorkCover capped claims cost as of 31/7/2016 ($19,745,000) would represent a savings of $6,515,850 (see the WorkCover claims table on p. 29 for further relevant figures).

PwC (2014) developed the model used by beyondblue’s Heads Up division for creating a 1/3rd reduction in the cost of WorkCover,
Absenteism and Presenteeism. It is essential to understand that to achieve the impressive results projected by PwC, MFB will need to address six “critical factors” that must operate as an organisational foundation from which to implement Wellbeing strategies. These ‘critical factors’ quoted from PwC are:

1. **Commitment from senior organisational leaders and business owners** - Organisational leaders and business owners must make visible, long-term commitments to improving and maintaining good mental health in their workplaces if they want to create lasting positive change.

2. **Employee participation** - Employee participation is essential to improving mental health in the workplace. Employee input must be sought in every step, from planning through to implementation and review.

3. **Develop and implement policies** - Policy lays the groundwork for action. It needs to be clearly articulated and flexible enough to meet the needs of the organisation or business.

4. **Resources necessary for success** - Initiatives aimed at improving mental health in the workplace require adequate resourcing if they are to succeed.

5. **A sustainable approach** - Initial success requires ongoing effort to be sustained permanently.

6. **Planning** – Successful implementation will be well thought out, identifying the intended goals and objectives, including the inputs required – such as financial resources, time or additional staffing.

These critical factors are needed to establish an organisation’s ability to create and implement a comprehensive and well integrated wellbeing program as part of how the organisation does business.

The model developed then identifies seven action areas to be implemented from a whole of organisation approach. These actions are:

1. “Worksite physical activity programs
2. Coaching and mentoring programs
3. Mental health first aid and education
4. Resilience training
5. CBT based return-to-work programs
6. Wellbeing checks or health screenings
7. Encouraging employee involvement”

The final Report recommendations and the DRAFT Mental Health and Wellbeing Plan (2016 – 2018) have incorporated the six critical organisational factors and from this foundation developed an extensive set of strategies that effectively meet all seven actions suggested by PwC.

**4.10 Implementing ‘best practice’ within MFB**

To logistically implement the recommendations of the Final Report and the DRAFT Mental Health and Wellbeing Plan, with the “resources necessary for success” (critical factor 4), an Actuarial Statement may be of benefit. There is a growing acknowledgement within Emergency Services strategic planning for the use of provisional Actuarial Statements. For the MFB, this would theoretically state that “with a workforce of 2200 people, and an expectation that (in any given year) 20% of those staff will be experiencing a mental health issue is not unreasonable, given that this is the Australian average (ABS research, 2010). This therefore equates to 440 people per annum requiring services. Whilst not all of those will choose to go within the MFB to have this need met, planning for service delivery also needs to take into account that approximately 20% of MFB staff members’ families will also be experiencing a mental health issue, for which MFB may also be called upon to assist with clinical service provision.

For the remaining 80% (as an estimate, using the ABS research) of the workforce that are not experiencing clinically significant distress in any given year (a figure which currently sits at 1760 staff), consideration has to be given with regard to assisting them to remain healthy and resilient. Investment in the areas of prevention and early intervention are paramount, and from an ESP service delivery perspective this translates into
providing Mental Health First Aid and mental health (including challenging stigma issues relating to mental health and help-seeking), providing organization wide Wellbeing Checks, incorporating Resilience based training across the lifespan of the employee, and assisting with coaching and mentoring (PwC action areas two, three, four and six).

**Mental Health Continuum**

Majority of the workforce remains functional in the face of adversity

Minority of the workforce require more intensive support in the face of adversity

The Review team noted that the original Terms of Reference for this Review were added to by the CEO and the Board, to include the following (ToR number six):

"Make recommendations for ongoing evaluative processes of specific programs within Employee Support to help ensure optimal ongoing quality and effectiveness, including suggested resourcing".

In light of this request, the Review Team has attempted to operationalise the delivery of the good practice framework, both in terms of staffing and a suggested timeline/prioritising of key actions (detailed on the next page).

From a staffing perspective, this means that the majority of the resourcing needs to be placed at the 'functional' end of the mental health spectrum, while a smaller (but significant) amount of resourcing needs to be available for those experiencing adversity. Given MFB's size, spread and organisational risk profile (discussed in more detail in chapters seven and eight) and in order to meet the best practice guidelines identified by PwC and *beyondblue*, the following resourcing is suggested:
<table>
<thead>
<tr>
<th>Mental Health Continuum position</th>
<th>Resourcing recommendations</th>
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| Functional in the face of adversity (majority of MFB's workforce) | **Peer Support program**  
Aim to have a Peer to staff ratio of approximately 1:20 (120 Peers).  
Employ a second Peer Support Coordinator to deliver best practice proactive services (eg. Peer based training, support of the Peer Support Officers, program design and review) as well as the required reactive services (eg. critical incident service responses). Current service demands mean that the single Peer Support Coordinator is working a significant number of excess hours. |
| Functional in the face of adversity (majority of MFB's workforce) | **Clinicians**  
**1.0 FTE Wellbeing Check clinician**  
In order to be able to deliver annual wellbeing checks and the wellbeing psycho-education component of the checks throughout the organisation, a single FTE clinician is required. The brief interventions during wellbeing checks will be of particular benefit to those transitioning along the mental health continuum from healthy to ‘reacting’ or ‘injured’. These effective and timely brief interventions can assist to prevent further movement along the mental health continuum towards becoming 'ill'. This one FTE position will also contribute towards the review of training frameworks, program designs and evaluations, as the "organisational intelligence" gleaned from the wellbeing checks will inform ESP strategy. Currently, this service is being primarily provided by a contracted clinician, as the service demand is above and beyond capacity for the EAC to deliver.  
**2.0 FTE capacity and capability building clinicians/trainers**  
These two FTE positions will achieve two core functions as part of a process of continual quality improvement. One function will be to complement the work of the Peers by providing both a more in-depth psycho-education approach to wellbeing, resiliency, mental health literacy, capability and capacity building. The second function will be to review the training frameworks program design and evaluation to ensure preventative strategies remain contemporary evidenced based practices. These roles will provide Peer training and Peer supervision, as well as be available to assist with organisational supervision and support. |
| Psychologically impaired, and requiring more intensive support (minority of MFB's workforce) | **2.0 FTE Clinical Counsellors**  
These two positions will continue to complement and build upon the wellbeing and resiliency framework in their application of specialist trauma clinical interventions, including working with cumulative trauma, PTSD and sub-syndromal PTSD presentations, as well as other high prevalence disorders. These clinical interventions will address maladaptive coping strategies to adversity such as alcohol and other substance abuse, detrimental changes to nutrition, reduced exercise patterns, poor quality sleep patterns, reduced interests, poor ability to regulate and manage emotions and deteriorating social relations including those of work colleagues, families and friends. These positions would also have capacity to assist with return to work/career planning for those staff not able to perform their normal work role.  
Currently, this service is being provided by contracted clinicians (to the effect of approximately 1.2 FTE). |
4.11 Timeline recommendations for ESP resourcing

It is expected that the roll out of the MFB Mental Health and Wellbeing Plan, of which these resources represent a part, would take time. Therefore, the suggested plan would be to allow for the following phases:

- A recruitment phase for the second Peer Support Coordinator, as well as initially two clinicians/trainers.

- The induction of the new staff.

- Interim clinical governance issues (CIS database and secure clinician storage) be addressed.

- The EAC would go 'off line' with regards to service delivery to plan for the strategic roll out of the DRAFT MFB Mental Health and Wellbeing Plan. The Review team understands that this has occurred at Victoria Police, after their Mental Health Review, and notes that this is consistent with the PwC critical factors for implementing organisational wellbeing practices.

- Additional recruiting to the three remaining clinical roles could occur once the strategic roll out was further advanced in terms of reviews and program development, as outlined in the final Report recommendations.

4.12 Senior Leadership Resiliency portfolio

To achieve the full potential of a comprehensive Mental Health and Wellbeing Strategy, including the cost savings projected by Heads Up, requires resiliency strategies to be integrated across the organisation. For integration across the organisation to occur, each Director will need to have an investment in creating and maintaining resiliency. It will be this shared investment in resiliency that will drive the integration of resiliency strategies across the organisation’s activities. To understand how resiliency applies to all activities of the MFB may require a Senior Leadership in-service.

The in-service would help to create a 'resiliency lens' from which to monitor all MFB activities in terms of identifying potential risks to resiliency and to mitigate these risks and to identify protective factors that create resiliency and how to strengthen these. Risks and protective factors to resiliency can occur at all levels of communication and interaction with staff. An integrated process to create and maintain resiliency will require consistency of communication and behaviours from all staff that reinforce being and feeling safe both physically and psychologically.

Although overall responsibility for Mental Health, Wellbeing and Resiliency programs should remain with the Director of People and Culture, awareness of what constitutes resiliency and how this is applied throughout the MFB needs to be a responsibly shared by all. This point is highlighted by PwC as the first critical factor for implementing organisational wellbeing strategies, and can be further unpacked within the PwC document.

4.13 Clinical Governance

Clinical governance is a term normally associated with the health industry, and refers to a framework through which health organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellent clinical care will flourish. While MFB is not a health care body, the services delivered by the ESP and its contracted staff represent a health service to the organisation, and would benefit from having similar standards applied to its service development and delivery.

The Review team identified a number of issues that need to be addressed to ensure clinical governance standards are met. Currently there is an absence of:

- Consent and documentation to participate in Wellbeing Conversations or Checks
• Secure electronic document storage for clinicians (currently all clinical documents are located off site with individual clinicians, which potentially raises business continuity and clinical oversight risks)

• Ability to assess and ensure evidence based practices are adhered to that confirm the MFB practice framework

• Tracking of cumulative risk in operational staff and Peer Support Officers

• Psychological Autopsy processes following the death of an MFB staff member (particularly in the case of deaths by suicide).

4.14 Recommendations

As the ESP was initially resourced with a more direct service delivery role and with substantially fewer Peers, it is timely to review and update resourcing in line with service demand and current best practice. The Review team therefore recommends an increasing of the ESP FTE to implement the Mental Health and Wellbeing Action Plan. This is mirrored, at least in the area of PTSD, in the Fire Services Review (2015) where it noted that “Post Traumatic Stress Disorder (PTSD) is a feature of emergency services workforces across the globe. The fire services must ensure that their existing programs are sufficiently robust to provide appropriate levels of support” (p. 39).

These recommendations consist of the following:

Staffing

4. A second FTE Peer Support Coordinator (a review of pay structure is also recommended, to make the role more attractive to operational staff who might otherwise experience a reduction in pay to take on this role).

5. With regard to clinical services, five FTE employees (clinicians and/or trainers) to assist with the provision of mental health screening, training and education, triaging and clinical support services (including clinical supervision of Peer Support Officers), as detailed earlier in this chapter. This could commence with two clinicians, as discussed earlier in the Timeline recommendations; however it is anticipated that five would be required to deliver ‘best practice’, to recoup the projected WorkCover savings (detailed in chapter six), and to accommodate the potential increase in mental health service demands.

Resourcing

6. An externally housed critical incident database is required to manage organisational risk issues, and to document operational response processes to MFB critical incidents (along the lines of the Tasmanian and Queensland models).

7. Electronic resourcing for confidential storage of mental health documentation, such as Wellbeing Checks, internal clinical notes, and other related materials (eg. external contractor notes).
4.14 Recommendations (continued)

8. Resourcing dedicated to the development of targeted resilience and wellbeing information, comparable to the Department of Defence High Res App/website, in order to assist Employee Support staff in the roll out of training and maintenance of resilience and wellbeing strategies.

Other recommendations

9. Scope be granted for the Employee Assistance Coordinator to review the DRAFT MFB Mental Health and Wellbeing Plan, and strategically plan its implementation.

10. Undertake an audit of ways in which ESP is notified of mental health and wellbeing concerns, as well as program responses.
5. Mental health literacy and stigma in MFB

5.1 Key findings

- **Current mental health literacy and stigma reduction initiatives across MFB are somewhat ad hoc and lacking in reach and coordination.**

- **There is a need to increase and better coordinate mental health literacy and stigma reduction initiatives, with the goal of increasing earlier employee help-seeking behaviour.**

- **The most common form of mental health stigma observed across MFB is avoidance or delay in help-seeking due to feelings of embarrassment or shame (eg. 'self-stigma').**

Mental health literacy and stigma are challenging issues across all emergency service organisations. Mental health literacy refers to general awareness and understanding of common signs of mental health issues while stigma refers to barriers to help-seeking.

Generally, two forms of stigma are recognised in the mental health literature: self-stigma (where there is some recognition of symptoms but avoidance of help-seeking due to feelings of shame or embarrassment) and social stigma (avoidance of help-seeking due to fears that one may be marginalised, experience detrimental consequences on career prospects, or in other ways treated differently as a consequence).

"Cultural resistance to change and stigmatising attitudes are present to some extent in all emergency services organisations. These barriers are a product of outdated attitudes toward mental health issues, still present in many organisations, and poor perceptions or poor past experiences of mental health support services."

* beyondblue (2014) p.7

Historically in Australia, some 15 years ago, beyondblue and Mental Health First Aid introduced the templates for mental health education and awareness training and stigma reduction, which have been very influential on a range of mental health service provider groups. The reason that mental health literacy and mental health stigma are so important is because the goal of all programs is ultimately to validate and increase early help-seeking behaviour. The earlier an individual accesses relevant support and treatment, the disruption will be relatively less to their functioning and the recovery time tends to be shorter.

Not unexpectedly, the Review team found indications of a continuing need to build mental health literacy across MFB, both generally and in relation to the issue of suicide. The medical and psychology clinical service providers that were interviewed spoke about many employees who, in retrospect, indicated that they would have sought help earlier if they had better recognised that the symptoms they had been experiencing for some time were actual indicators of a developing mental health problem.

"Initially I was reluctant to put my hand up too early in my career and request this training, but now I’m kicking myself – why didn’t I do it sooner?"

Firefighter, on completion of Mental Health First Aid and ASSIST suicide training

The Review team also noted a generational effect with younger employees being more aware of mental health issues and more willing to discuss them relative to older age employee cohorts. This is not unusual and probably also reflects community wide progress in mental health literacy and stigma reduction that has occurred progressively over the past 15 years in Australia. However this may have particular relevance for MFB given that there is a
large cohort of older firefighters (aged 45+), who may have different expectations and experiences compared to younger cohorts.

The Review team identified the most common form of mental health stigma in MFB as self-stigma, i.e. a denial or avoidance and delay in help-seeking due to feelings of embarrassment or shame, and a belief that the employee should be robust and resilient, and hence not require any help. Another challenge (and possibly an avoidance behaviour associated with self-stigma) is that the Review team heard of staff avoiding or delaying help-seeking due to difficulties in scheduling health care appointments, particularly for firefighters who had ‘cas work’ (i.e. a second job on their days off) or family commitments (e.g. child minding on days off).

"I support other people so I shouldn't need to support myself"

Firefighter

"What they say is that we are the heroes who assist others and should not be affected by what we do"

Psychologist commenting on firefighter attitudes

This is also particularly important in relation to the potentially cumulative effects of operational incident experiences on firefighter mental health. Addressing this issue requires both individual level targeted initiatives (e.g. mental health literacy training) as well as organisational level initiatives. The latter is discussed in chapter six in more detail.

Of note, the Review team found relatively lower levels of social mental health stigma. There were fewer indications of fears of marginalisation or detrimental consequences (e.g. to career prospects) due specifically to mental health issues than is more commonly found in other emergency service organisations.

One minor social stigma nuance was raised by a few employees who indicated a reluctance to seek support from a Peer. This was because they knew the Peer and had worked with them or had an ongoing work relationship with them. They stated that this made them more reluctant to speak with a Peer because, essentially, they felt the Peer might perceive them differently in the future. It must be emphasised that this was considered to be a relatively minor barrier by the Review team. Overwhelmingly the Review team found that the Peers are effective as the front line contact for MFB employees and serve as a crucial pathway towards accessing care and support. It was noted that the possibility of speaking with a different Peer could be promoted to help address this, the proviso being that there are in fact enough Peers to offer this alternative. This also reinforces the need to have available multiple pathways to accessing support and treatment, which MFB currently does.

The Review team found that, currently across the MFB, mental health literacy and stigma reduction training is insufficient and needs to be significantly augmented. Some content is delivered by Peers on an ad hoc basis, and sessions of Mental Health First Aid (two day training program) are offered to interested staff (although operational staff are expected to complete this in their personal time). As a point of reference, Ambulance Victoria is currently in the process of rolling out a $1.2 million dollar investment in a whole-of-organisation mental health literacy program.

Further, there appears to be negligible training available for managers on conducting ‘wellbeing conversations’ (i.e. proactive supportive conversations with at-risk individuals, initiated by a manager, with the goal of encouraging them to seek appropriate care or treatment).

The Review team received consistent feedback from numerous interviewees that many were uncertain or lacked confidence in initiating wellbeing type conversations with employees.

It was noted that there is some content in leadership programs on ‘challenging conversations’ oriented towards performance management issues. Further, there is some content delivered by Peers on dealing with distressed people at call outs.
The Review team noted there is a need to augment and better coordinate mental health literacy, stigma reduction and wellbeing conversations from an organisation-wide perspective. This is a critical initiative that will contribute towards improving mental health and wellbeing outcomes and suicide prevention. And while it is noted that Mental Health First Aid training has been delivered within MFB since 2010, and has trained approximately 400 people (including the 80+ Peer Support Officers), the Review team notes the difficulty in asking operational staff (who represent about 85% of MFB’s workforce) to attend this training in their personal time/days off, without offering Accrued Leave, when corporate staff are able to undertake the training during their normal working hours.

The Review team concluded that the most cost effective way of developing an MFB organisation-wide mental health literacy program would be to develop some revised content, probably with input from an expert external provider, and then deliver this through multiple strategically coordinated channels: peers and clinicians providing seminars in a more systematic fashion; general online resources available to employees; incorporating some content into the regular online skills update training and; embedding content into all levels of leadership training programs. It is further noted that the interpersonal skills underpinning the conduct of ‘challenging’ and ‘wellbeing’ conversations and dealing with distressed people are more or less identical. Hence, the Report recommends that a wellbeing component be added to an expanded conversation training module.

5.2 Mental Health literacy

The key goals and content of a mental health literacy program should include:

a. Increase recognition of early warning signs.

b. Provide accurate information about mental health issues including risk and recovery prospects and suicide.

c. Detail the benefits of and encourage early help-seeking behaviour.

d. Provide information about key evidence-based treatment options for common mental health conditions.

In relation to (d), it is recommended that some content from the recently released Black Dog Institute (2015) be included and the language adapted to be suitable for all employees.

e. Clarify appropriate ways to engage with and support a person in the workplace who may be experiencing mental health-related difficulties.

f. Foster a sense of shared responsibility among employees ‘for looking out for one another’, or as has been described elsewhere, the ‘Mates for Mates’ concept. There will be occasions when a colleague is the first to notice that another team member is struggling and should feel empowered to be able to approach them directly and encourage them to seek help.

g. Provide an emphasis on leadership modelling of good mental health and wellbeing practices.

A further issue considered by the Review team, in relation to employees avoiding seeking help, is highlighted by the quote below regarding the impact of past negative treatment experiences:

"I didn't like the [external EAP] counsellor and they didn't help me so I haven't bothered to see anyone else - I just put that stuff away somewhere and I avoid certain situations now. That's how I cope"

Senior Firefighter

These types of 'once bitten twice shy' counselling and treatment experiences do have a detrimental impact on future help-seeking. As noted in chapter four, there has been some negative feedback about the counselling services provided by the external Employee Assistance Program. It must be emphasised that this is not unique to MFB or the particular current external provider contracted by MFB. It does appear to be more common in emergency service organisations. However it
is important to note that treatment concerns are sometimes highly warranted: the recent Victoria Police Mental Health Review (2016) states “the WorkSafe Clinical Panel reviews suggest that approximately 50% of injured frontline responders (and all injured workers suffering from PTSD) still do not gain access to the most appropriate treatments”.

On balance, the Review team considered there is a continuing need for an externally contracted EAP program. This takes into account the need for a broader range of indicated services including relationship counselling and geographical spread of service providers. To further improve EAP service delivery, the Review team supports increasing the triaging function that has recently been introduced via the Employee Assistance Coordinator (eg. as occurs in Victoria Police) to better match particular counsellors with individual employee needs. Further, the development of a specialist ‘preferred providers’ list who have knowledge and expertise in trauma and first responder services and could be referred to separately from the EAP provider (eg. specialist substance abuse detox/rehab centres), would be advantageous (and could be shared with other Victorian Emergency Service organisations).

At an organisational level, the Review team concluded that mental health literacy and stigma reduction is a cost effective upstream initiative. It is a key initiative aimed at validating and increasing early help-seeking. Investment in tertiary treatment resources is still required, but effective mental health literacy and stigma reduction programs are associated with reduced treatment costs. As mentioned earlier, the Review team noted with interest that Ambulance Victoria recently signed off on an organisation-wide mental health literacy and stigma reduction program as the core element of their new comprehensive three year organisational mental health strategy. Victoria Police is also currently developing an organisation-wide mental health literacy program as a central feature of its new mental health strategy. This approach can be extremely cost effective. Studies indicate that every dollar an organisations spends in wellbeing, resiliency and mental health literacy saves the organisation $2.30 in costs associated with WorkCover, absenteeism and productivity losses. The figures are conservative as they do not include the costs of high staff turnover, brand damage and lost opportunity costs from reduced innovation (PwC, 2014).

5.3 Recommendations

11. Review and update existing mental health education and awareness content (including suicide awareness content) with consideration to consulting an external subject matter expert. Organisational investment in a comprehensive mental health literacy and stigma reduction program is a cost effective way of improving mental health and wellbeing outcomes: earlier help-seeking reduces levels of disruption to employee functioning and reduces downstream treatment costs.

12. Develop an organisation-wide mental health literacy strategy involving multiple delivery modalities including peer presentations, clinician presentations, on line resources and embedding content in leadership training programs.

13. Expand the triage process with the external EAP provider to increasingly match presenting employees with the most appropriate counsellor. This process should be undertaken by the Employee Assistance Coordinator, or clinical staff within the ESP.

14. Organisational leader role modelling and ‘champions’ should be supported and developed to ensure program effectiveness via a ‘top down’ approach.
6. Occupational Health and Safety

6.1 Key findings

- There is a lack of organisational systems to monitor and proactively address the possible effects of cumulative incident exposures. This is a major organisational psychological health and safety risk that needs to be urgently addressed.

- EMR is another area of organisational psychological health risk also related to the potential effects of workplace trauma/cumulative exposures.

- There is currently insufficient matching of ESP initiatives according to MFB’s risk profile; ie. directing more initiatives according to risk levels, eg. stations that perform relatively higher levels of EMR.

- The current MFB occupational health and safety and workers compensation performance is extremely poor when benchmarked against all relevant industry standards.

One aspect of the increasing focus on workplace mental health issues is the accentuation of the psychological dimension of occupational health and safety. For example, WorkSafe Victoria released new guidance materials for employers on preventing work-related stress in early 2016. The term ‘psychological health and safety’ is also increasingly being used. The National Standard of Canada for Psychological Health and Safety in the Workplace (Mental Health Commission of Canada), which delineates 13 workplace psychosocial elements that influence the psychological health of employees, has been influential in shaping current psychological health and safety initiatives in Australia. Further, WorkSafe, Vic Health and Super Friend have recently formed the Victorian Workplace Mental Wellbeing Collaboration to promote positive mental health and workplace protective factors.

A key principle in occupational health and safety concerns is calibrating risk mitigation initiatives according to the organisational risk profile. This Report has already discussed (in chapter three) what is known about the range of mental health issues encountered across MFB. In terms of risk, the Review team identified cumulative exposure to potentially traumatic incidents and EMR as two key areas of organisational psychological health and safety risk, as well as issues relating to the WorkCover and injury management process.

6.2 Cumulative trauma risk

In relation to current MFB practices around the risk of cumulative exposure, the Review team noted that Peers visit groups of employees or individuals as requested. There is occasional proactive contact, but this is largely on an ad hoc basis.

Overall, responses continue to be largely reactive and are not systematic. In the messaging from Peers there is an emphasis on employee self-responsibility to initiate contact with the ESP. This is certainly appropriate but needs to be balanced with organisation proactive initiatives. This is critical in the area of potentially cumulative traumatic stress responses as the post-traumatic stress literature emphasises the role of avoidance behaviour as a key feature of PTSD. Indeed, there are Australian legal precedents where employees have received significant payouts when courts have deemed that there was insufficient organisational follow-up of individuals suffering from PTSD (McFarlane and Bryant, 2007).

“They come in beating themselves up because they are not coping – there is an accumulation of stress responses. This is common. We are not getting to them early enough.”

Medical Advisor
"Often the symptoms are well entrenched by the time I see them."

**Contracted Psychologist**

As indicated in chapter five, the Review team believes that traumatic stress symptoms are underreported across MFB. During the wellbeing checks, participants consistently identify significant levels of sub-syndromal PTSD markers, however they tend not to report these or seek help, until the symptoms have become unmanageable. This is likely to be due to a combination of mental health stigma (particularly self-stigma discussed in chapter five) and the avoidance behaviour that is common in employees with accumulating traumatic stress reactions.

The Review team found that this is a significant organisational risk; namely, the lack of any system for tracking cumulative exposure and triggering a proactive organisational response. Currently there is excessive reliance on individuals to trigger a response and this is too ad hoc. In the opinion of the Review team, this must be addressed as a matter of urgency. There are a number of options and the Review team defers to MFB to consider an appropriate system. However it is noted that this would represent an increase in the critical incident workload, for which additional resourcing has already been recommended.

As one example from another organisation we note that Victoria Police has trialled, and is currently in the process of implementing, a state-wide online psychological risk register (safe-t-net) that tracks all incident exposure, includes employee ratings of impact severity and triggers a welfare conversation with that employee's manager. After a certain number of incidents that cross a rating threshold, a response from Police Psychology will be triggered. The Review team notes that questions have been raised as to whether this process could be replicated within MFB's online OH&S system for recording and managing incidents and hazards. However, on initial reflection, this does not appear possible. Firstly, MFBSafe is not capable of tracking cumulative data, and secondly (and perhaps most significantly for MFB staff) it has actual as well as perceptual limits to its confidentiality. This latter issue is why Victoria Police had safe-t-net built as a separate register to its own OH&S risk register.

In relation to this issue, the Fire Services Review (2015) on page 57 recommends, "... MFB consults with other emergency management agencies to determine if the relevant systems they are using might be of benefit to MFB or if those agencies would also like to use the system being contemplated by MFB. MFB is encouraged to move beyond an ad hoc approach and develop, with the sector, a more cohesive view of information technology requirements".

The Review team noted that Tasmania and Queensland Fire and Emergency Services have existing systems that warrant further investigation in relation to their potential to addressing both the issue of risk and cumulative risk at an operational staff level, as well as the vicarious/secondary trauma risk associated with Peer and ESP service delivery.

### 6.3 Emergency Medical Response (EMR) risk

In relation to EMR, the Review team noted indications from a range of interviewees of ambivalent and sometimes more actively negative attitudes towards EMR. The more negative responses seemed to be more pronounced in the older age employee cohort. EMR is challenging.

"We thought it would be about dealing with old people and breathing problems. But we see infant deaths, teenage suicides and distressed and blubbering family members and bystanders."

**Firefighter**

"When the tones go off for a fire, you can look around and see everyone perk up – this is what we signed on for! But when we hear it’s an EMR, you can see us slump, just a little. We look and feel weighed down, wondering what we are walking in to."

**Firefighter who joined prior to EMR roll out**
EMR was introduced in 2001. For an older cohort of firefighters it was not part of the job that they started in, whereas for the younger cohort it was already part of the job. While there is the possibility for the older cohort members to 'opt out' of providing EMR, at a practical level this means that any firefighter who chooses to do so may still be left dealing with the distressed relatives and bystanders, which is a role that may cause more psychological distress than actually providing EMR.

The Review team speculated that an overlay of 'psychosocial factors' may explain these apparent differences. Based on interviews undertaken, the Review team concluded that this likely includes: job role expectations (eg. strong and deeply felt views about parameters around the traditional firefighter role that does not include EMR); and also personal characteristics (eg. aversion and discomfort in dealing with human emotions). The latter may be an indicator of a need to review recruitment practices around the assumed personality profile of the ideal firefighter.

EMR events are not evenly distributed across the workforce. There are certain hot spots linked with the demographics of the geographical area that each station services. The Review team found that currently there is insufficient calibration of ESP contacts and follow-up according to the overall risk profile (ie. more proactive visits to areas with higher levels of ESP involvement, and graded therefrom).

6.4 WHS performance and WorkCover

More generally considering MFB’s occupational health and safety performance, the Review team noted that currently MFB is performing at a level that is 93% worse than all relevant industry benchmarks, and further deteriorating according to available indicators (MFB Workcover Premium notice 2 July 2016 Gallagher Bassett Services Workers Compensation Vic Pty Ltd).

Similarly, MFB workers compensation performance is very poor. Out of all Australian fire and emergency services agencies, MFB ranks as the second worst performer (AFAC, December, 2014). Of these 14 fire and rescue agencies MFB has 9% of all employees in this group yet accounts for 16% of all claims. Considering only Victorian agencies (eg. CFA, Dept. of Environment and Primary Industry, MFB, Parks Victoria and State Emergency Service) MFB claim frequency rate is relatively much higher (16.6%). The next highest is CFA with 5.31% – and this is evidently substantially lower than MFB.

From the 2014 – 2015 MFB Annual Report, 9% (160 employees) of its operational workforce at any time is on WorkCover or long-term sick/injured. MFB was performing “69.47 per cent worse than fire and other emergency services sector’s performance”. This has increased to 93.21% worse with receipt of the 2016-2017 Premium Notice. As a comparison, Victoria Police has a $54 million Workers Compensation premium profile across 18,000 staff, which represents a rough cost per head of $3000 per person. MFB is currently spending $14.2 million across approximately 2200 staff, which represents a rough cost per head of $6,455 per person, which is expected to increase given the current trending.
The table below demonstrates the significant rise in costs and claims within the MFB between 2011-2012, and 2016 – 2017:

<table>
<thead>
<tr>
<th>Year</th>
<th>Total claims</th>
<th>LTI Claims</th>
<th>LTFR</th>
<th>Capped claims cost</th>
<th>W/C Premium</th>
<th>MFB Premium rate</th>
<th>Industry rate</th>
<th>Relative claims permanence compared to industry</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011 - 2012</td>
<td>316</td>
<td>208</td>
<td>50.68</td>
<td>$15,786,486</td>
<td>$9,969,583.73</td>
<td>4.14%</td>
<td>2.94%</td>
<td>40.82% worse</td>
</tr>
<tr>
<td>2012 - 2013</td>
<td>351</td>
<td>225</td>
<td>52.02</td>
<td>$14,718,756</td>
<td>$10,021,732.59</td>
<td>4.20%</td>
<td>2.91%</td>
<td>44.56% worse</td>
</tr>
<tr>
<td>2013 - 2014</td>
<td>371</td>
<td>226</td>
<td>58.16</td>
<td>$15,920,503</td>
<td>$10,360,177.72</td>
<td>4.02%</td>
<td>2.77%</td>
<td>44.84% worse</td>
</tr>
<tr>
<td>2014 - 2015</td>
<td>315</td>
<td>177</td>
<td>50.89</td>
<td>$15,835,966</td>
<td>$10,863,851.25</td>
<td>3.89%</td>
<td>2.72%</td>
<td>42.89% worse</td>
</tr>
<tr>
<td>2015 - 2016</td>
<td>372</td>
<td>214</td>
<td>57</td>
<td>$17,172,504</td>
<td>$12,070,697.47</td>
<td>4.38%</td>
<td>2.58%</td>
<td>69.74% worse</td>
</tr>
<tr>
<td>2016 - 2017</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>$14,223,131.49</td>
<td>4.94%</td>
<td>2.55%</td>
<td>93.21% worse</td>
</tr>
<tr>
<td>31/07/2016</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>$19,745,000</td>
<td>as at 31/7/16</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The Review team found that a number of factors are contributing to this significantly poor performance. Workplace cultural factors, the industrial relations context and a lack of certain workforce health management practices are significant (discussed in chapter six), as well as a lack of focus on standard injury management procedures and practices (discussed in chapter eight).

Additionally, the Review team noted concerns regarding the absence of formal case planning in Work Cover/Return To Work planning. While ad hoc conversations and planning does occur between the ESP, WorkCover/Return to Work and Health and Fitness staff, this process does not meet the standards required for assisting staff experiencing a mental illness.

For additional reading as to how to deliver best practice, refer to the University of Melbourne document Helping employees return to work following Depression, Anxiety or a related mental health problem: guidelines for organisations (2011). Simple strategies such as having an information pack to send to staff regarding injuries and the WorkCover process are also highly recommended.
6.5 Recommendations

15. As a matter of priority, MFB needs to implement a structured case management and case planning approach to dealing with staff who are psychologically injured (this includes those who are on light/ altered duties, those who are on variations of ‘sick leave’ and those formally engaged in the WorkCover process).

16. An organisational system for tracking cumulative exposure and associated psychological risks needs to be developed as a matter of urgency, to support the development of a more proactive contact regime with employees with higher potential levels of psychological risk.

17. MFB needs to develop an organisation-wide psychosocial risk register to guide the proactive targeting of mental health and wellbeing initiatives.
7. MFB organisational culture and contextual factors that influence employee mental health and wellbeing

7.1 Key findings

- The Employee Support Program is generally regarded as being neutral and positioned outside of the ongoing polarising MFB industrial relations challenges.

- However, there are certain unique MFB cultural features that do inhibit appropriate help-seeking behaviours and timely access of mental health services.

- In terms of MFB culture, stations are characterised as family like tribal sub-cultures that are highly supportive but not necessarily inclusive.

- This type of sub-culture tends to shield and hide physical and mental health risk.

- The ongoing industrial relations disputation and media coverage is associated with declining morale and increasing psychological health and safety risk.

- The extreme lack of MFB workforce diversity, lack of mobility and access to flexible working hours contributes to psychological health and safety risk. Improving these factors would contribute towards improving mental health and wellbeing outcomes.

- From a mental health and wellbeing perspective, the current VEOHRC Review is considered to be very important for the future of MFB.

- There is an excessively wide tolerance margin for inappropriate behaviours across the MFB and this directly contributes to psychological health and safety risk.

- There appears to be a lack of appropriate accountabilities, skills and sometimes motivation, among leaders to appropriately address behavioural issues.

Workplace mental health and wellbeing services (ie. MFB Employee Support Program) are delivered in a context: an organisational environment and culture that inevitably influences the perception of these services and their up-take and also influences levels of employee wellbeing and the incidence of mental health problems.

By and large, the Review team found that the ESP is perceived by employees as being neutral and standing outside of the ongoing polarising industrial challenges faced by the MFB. The ESP currently appears to be largely unscathed by these factors in terms of employee perceptions of neutrality and impact on service utilisation. The Peers, as the front line ESP contact and pathway for employees to access other ESP services, also appear to be regarded as predominately standing outside of this fray.

However, in addition to mental health stigma related barriers (as discussed earlier), the Review team did find that there are certain MFB cultural features that do inhibit appropriate and early (or optimal) engagement with treatment resources.
7.2 Organisational culture

Organisational culture or climate\(^1\) consists of the day-to-day experience that employees have of policies, practices and procedures, leadership style and behaviours that are observed to be rewarded or discouraged. It is essentially the psychosocial dimension of the work environment and exerts a significant influence on employee motivation, morale and wellbeing.

Key features defining MFB culture, as identified by the Review team, include the underpinning venerable operational firefighting tradition, the enduring and damaging industrial relations context, the perception of an unbridgeable gap between the corporate and operational realms, and the extreme lack of workforce diversity. Further, at the station level there can be negligible movement or rotation and thus these groups of employees spend long periods of time together, inevitably forging strong and enduring social bonds.

Stations are effectively semi-autonomous sub-cultures within the broader MFB culture. The Review team characterised fire stations as being family-like, tribal and highly supportive sub-cultures that are not necessarily inclusive. Provided an employee fits in, they are embraced and strongly supported consistently through highs and lows over the course of their career.

The downside of this type of sub-culture is that where individuals do not fit in, they are more likely to be ostracised and experience increased psychological health risk. The Review team heard many stories from employees, particularly from women and others who are not typical anglo-celtic males, of being marginalised or bullied. By contrast, and not surprisingly, most firefighters the Review team spoke with reported not having observed any bullying behaviours.

All of the women interviewed by the Review team, except one, reported experiencing significant gender-based harassment, sexism and misogyny.

"You have to be tough as nails to get ahead."

"The prevailing view out there is that they are changing everything to make it easy for women to get in ... this causes resentment."

"The sexism is pervasive."

"After I’d finished my course [promotional training], I was assigned to a new station. At muster, everyone gathered in the yard and then refused to shake my hand when I tried to introduce myself. Everyone in the district knew this stuff was going on, but none of the other Officers would help”.

comments from current and former female staff

Extreme lack of workforce diversity tends to be associated with higher levels of mental health problems. It is well established that workforce diversity and inclusive cultures, as well as employee access to flexible working arrangements, contribute positively towards the mental health and wellbeing of employees. The Review team notes the recently commenced VEOHRC Review and considers that, from an employee wellbeing perspective, this is very important for the future ‘organisational health’ of MFB. The Review team also notes that Diversity and Inclusion is a key focus of the Valuing Our People Strategy in the MFB Plan.

A further downside is that this type of sub-culture tends to shield and hide occupational health and safety risk. In some instances individuals are probably over-supported: the Review team heard anecdotes about employees who allegedly are unable to bend over and tie up their shoelaces, but still get ‘carried’ on to trucks to attend call outs.

\(^1\) For present purposes, the terms culture and climate are used interchangeably. In strict terms, as used in the scholarly literature, climate is the more appropriate term. Culture is about deeper norms and values that are not readily apparent and cannot be easily measured or changed. Climate can be described as the ‘face of culture’ and can be more readily measured and changed.
The Review team concluded that this is also the case with mental health issues. Thus, in addition to the role of self-stigma in inhibiting help-seeking, the extensive social support provided at station levels often seems to unwittingly contribute to further delays help-seeking.

"We are pulling them out of the river and trying to save them, but nothing seems to be happening upstream to stop them falling in or pulling them out up there"

MFB Medical Advisor

7.3 Morale

The organisational research literature suggests that the incidence of mental health problems tends to be higher in very negative work environments where employees have low morale and hence reduced resilience in relation to coping with operational incident exposures. High levels of individual and team level morale increase resilience and are mental health protective factors. In the Fire Services Review (2015) it is stated, "Poor morale, if left unchecked, can result in reduced commitment, increased absences, increases in the number of errors, decreased productivity, decreased quality of work, apathy and increases in accidents or injuries." (p. 32).

"We are bunkered down, not really thinking about anything other than our safety. So very little happens, and nothing changes"

comment from a corporate staff member

The Review team found numerous current indications of declining morale across MFB - as reported by multiple interviewees. As one example, the term 'moral injury' was noted by two interviewees to describe their experience of abuse by members of the public in relation to the ongoing and now much-publicised industrial relations issues. This term appears to be a way of articulating the challenge to underpinning assumptions and values occasioned by changes in public perceptions of firefighters.

Previously operating on the assumption of being highly regarded by the public but now often viewed with more ambivalence, many employees are clearly struggling to reconcile this. It is clear that substantive damage has occurred to the 'firefighter brand'. One of the Review team likened this to a milder version of the Vietnam Veteran experience: from being unequivocal heroes to returning to a changed political climate and vilified by members of the public. At the time, PTSD experts described this as a 'secondary injury' that exacerbated the post-traumatic stress symptoms experienced by many soldiers.
The Review team concluded that the enduring damaging industrial relations context and associated media coverage and changed public perceptions is having an adverse impact on employee morale. The Review team also heard comments from people in senior roles, both corporate and operational, who felt that the organisational expectations of their roles were unmanageable and that they were burnt out by the workload. Hence, the Review team concluded that this situation is associated with increasing organisational psychological health and safety risk.

"I used to be angry, and anxious, about everything that was expected of me in this role [a promotional role]. Now I'm just apathetic. I'm not sure if that is better, or worse”

comment from a senior staff member

7.4 Workplace values and behaviours

Another critical organisational contextual element that impacts on the incidence of workplace mental health problems and outcomes is the status of an organisation's 'values and behaviours' policy and practice. A strong values and expected behaviour piece is associated with a reduced incidence of mental health problems, and is a significant employee mental health protective factor\(^2\). It is also a necessary prerequisite for a 'mentally healthy workplace'.

'Strong' means that policies are implemented in a way that exerts significant influence on employee day-to-day experience in a team environment (rather than merely being documents that sit in a bottom drawer, effectively having no practical impact). In such environments, there are narrow tolerance margins for inappropriate behaviours; managers role model appropriate behaviours and proactively promote civility and the principle of respect (ie. the expectation that all employees demonstrate a minimal level of courtesy and consideration in their interactions with co-workers); inappropriate behaviours are actively addressed in a consistent manner; employees hold each other accountable and feel empowered to call out inappropriate behaviours and; there are real consequences for poor behaviours.

The organisational behaviour research literature indicates that there is a role for 'restorative justice' in the workplace, and finds that 'learning oriented feedback' is generally most effective in achieving behaviour change (as opposed to punitive measures). However, this literature is also very clear that there are no genuine consequences for inappropriate behaviours, or where poor behaviour is selectively tolerated and exceptions are made, this can totally undermine the effectiveness of any organisational values and expected behaviours regime. Further, this can occur irrespective of any employee expected behaviours type training programs implemented. Where any of these elements are present, any such training programs struggle to gain any genuine traction and impact on behaviour change.

The Review team found that the current MFB work environment is characterised by:

a. an excessively wide tolerance margin for poor behaviours,

b. lack of appropriate accountabilities, and

c. inconsistent, or lack of, management of inappropriate behaviours.

In the opinion of the Review Team, this is a clear risk for the psychological health and safety of employees.

"I couldn't wait to move from Station ABC. In every break the group conversation always turned to sex and smut. It used to stress me out. It's much better here.”

male firefighter

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\(^2\) See VEOHRC (2015) and Victoria Police Mental Health Review (2016)
"Two people in my area were bullied by a uniformed manager over quite a long time. He was always really controlling. They made complaints and other staff backed them up. The only response was to 'just put up with it, it's his personality'. Eventually he was moved to another area but the problem was never addressed."

Corporate area employee

There are palpable examples of inappropriate behaviours in the MFB organisational environment ultimately having negligible consequences. These examples were widely referred to by interviewees that the Review team spoke with.

One operational interviewee told the Review team:

"You basically learn in induction that you can never be sacked, no matter what happens".

Another stated:

"No matter what you do, you always know that the Union will back you up".

All of this resonates with the findings of the Victorian Fire Services Review (2015):

"The Review also heard consistent stories of claims regarding poor or bullying behaviour being badly managed. In some instances, this was due to a lack of skills or lack of interest on the part of the responsible manager. In others, it was due to a lack of authority of the responsible manager, irrespective of how willing, to take any real positive steps towards resolution."

The Review team notes that a precondition for improving workplace mental health and wellbeing outcomes is that key stakeholders (eg. particularly executive leadership groups and unions) must work collaboratively together. The Review team noted the example of Victoria Police where the Police Association and Victoria Police leadership have historically experienced many industrial differences, but have both endorsed all 39 recommendations from the recent independent Victoria Police Mental Health Review and have committed to work collaboratively to implement all recommendations. Similarly, Ambulance Victoria overcame seemingly intractable industrial issues over remuneration, and now union representatives and senior leadership are partnering 'hand in glove' on a Psychological Health and Wellbeing Consultative Group, overseeing the current implementation a state-of-the-art mental health strategy. Moreover, both of these emergency service organisations have processes underway to increase access to flexible working arrangements and reduce tolerance margins for inappropriate behaviours.

Finally, the Review team notes that it has been perplexed by reported anecdotes about attempts to undermine the current VEOHRC Review process and also the blocking of a beyondblue initiative to support employees in relation to the issue of suicide. The Review team asserts that it is imperative that organisational mental health and wellbeing initiatives are quarantined from being drawn into industrial relations or politicised agendas.
7.5 Recommendations

18. It is imperative for achieving organisation-wide improvement in mental health and wellbeing outcomes, as well as suicide prevention, that key stakeholders work together collaboratively (ie. the Senior Leadership Team and the Union). The Review Team recommends that renewed efforts be made in this direction.

19. It is recommended that the process of increasing workforce diversity, access to flexible working hours and increased mobility continue, and be accelerated, as this will directly contribute towards achieving overall improvements in employee mental health and wellbeing.

20. The VEOHRC Review should be fully supported and embraced as it will also have important implications for the mental health and wellbeing of all MFB employees.

21. The option of a mandatory fitness for duty assessment process should be developed and positioned as an organisational early intervention tool to minimise risks to individual, organisational and public safety. This should include medical and psychological fitness for duty assessments.

22. That the drug and alcohol screening regime, scheduled in the MFB Always Safe Action Plan for 2016 - 2017, be prioritised and developed to include options for random and targeted screening.

23. In addition to the current employee behaviour training program currently being implemented, it is recommended that manager accountabilities at all levels be clearly re-defined and implemented and that manager training in proactively addressing behavioural issues be developed and implemented.

24. Finally, it is recommended that the Senior Leadership Team consider investing in people-focused leadership training and development. Further reading with regards to operationalising this action can be found in the Victoria Police Mental Health Review (2016), as well as the Department of Defence document Pathway to Change – Evolving Defence Culture (2012).
8. ‘Resilience across the lifespan’

8.1 Key findings

- While widely accepted in principle, a ‘whole of lifespan’ approach has yet to be formally and successfully implemented across MFB.
- A ‘whole of lifespan’ approach is hampered by organisational structure issues such as resourcing constraints and unintentional silo-ing between teams/departments.

Much like other emergency services organisations, the Review team found that there was much discussion, and even passion, about the idea of ‘whole of career’ resilience and wellbeing. This passion extended beyond purely operational roles, and included the need for support roles to be mindful of their own exposure to vicarious traumatisation. The Review team noted, however, that efforts to plan and deliver the key elements of such a focus were typically ad hoc and suffered from a lack of coordination/integration. This appeared to be partly related to the ‘working in silos’ issue that exist among most organisations. However it can also be partly attributed to departmental workloads impacting on the capacity of teams to regularly engage and review their roles and service delivery in respect to this concept.

From an organisational perspective, emergency services have a unique combination of:

a. exposure to traumatic incidents, including vicariously for non-operational role.

b. the potential for this exposure to be cumulative above Australian population level suicide rates.

c. workplace risk factors.

d. personal risk factors.

This warrants the development of a comprehensive ‘whole of career’ wellbeing and resiliency approach. Such an approach is supported by the Fire Services Review (2015) that states “support must be provided as a part of an overall, whole-of-working-life regime” (p. 3). A strong preventative focus (ie. wellbeing and resiliency) acknowledges that most people are already able to withstand considerable challenges. It is important to understand what creates this resiliency (ie. protective factors and how to strengthen these protective factors). For a smaller percentage of the workforce more intensive supports, including clinical interventions, will be required. As mentioned in chapter five, these supports require review to ensure that they are aligned to best practice.

The DRAFT MFB Mental Health and Wellbeing Strategy Objective one is to “promote and support mental fitness within MFB”. Under this section, priority action 1.4 details a ‘whole of career’ approach in which “the fourth goal addresses the ‘whole of career’ lifespan of mental fitness. It places a focus on resilience, in particular mindfulness-based resiliency. Building a developmental model of resilience into the employee’s career, from recruitment through to retirement, allows for improved mental health and wellbeing at the individual, group and organisational level”.

In order for the Mental Health and Wellbeing Strategy to be successfully implemented, Heads Up outlines four (4) key principles of good practice to consider from a whole of career approach. These principles are consistent with the findings and recommendations made thus far in this final Report. These principles are:

1. Shared responsibility
Thinking about health, safety and wellbeing should be as natural for everyone in the organisation as thinking about operational business activities.
2. Reducing risk and strengthening protective factors

Factors that are a potential risk to wellbeing should be identified and mitigated. Protective factors should be identified and strengthened as a priority. The reader is directed towards the beyondblue good practice framework for key organisational protective factors. In particular, the Review team notes with interest the growing efforts in international practice (e.g. the National Defence and the Canadian Armed Forces – Road to Mental Readiness) that incorporates strengthening family resiliency as part of this process.

3. Strength-based culture

A strength-based culture acknowledges peoples skills and talents, treats people with respect and validation, and acknowledges that diversity further increases the overall strength of the organisation.

4. Integrated, holistic approach

An effective Mental Health and Wellbeing Strategy requires both mitigating risk factors to resiliency and wellbeing, as well as building and strengthening protective factors. It is essential to approach this task from a whole-of-organisation perspective. Far greater positive outcomes will be achieved with coordination of efforts. The aim should be to ensure consistency of messages and behaviours that align with what is known to enhance resiliency. This will require a ‘resiliency lens’ at the executive level to monitor all MFB activities for opportunities to enhance protective factors.

8.2 Career stages and resiliency strategies

Overall, organisational investment in mental health and wellbeing needs to recognise that the majority of people, for the majority of the time, will not need clinical support (see figure below). Nonetheless, to maintain this state an organisational investment into protective factors and prevention/early intervention strategies is paramount.

8.2.1 Recruitment- screening and training

Heads Up suggests that screening for mental health vulnerability can be unreliable and that organisations need to consider remaining mindful of not developing discriminatory practices. On the other hand, police services and the Australian Defence Force utilise sophisticated psychological screening testing and report this to be effective in reducing mental health risk.

Based on this, the suggested approach for MFB is to strengthen the mental health screening strategies across the organisation to reduce risks to resiliency and enhance protective factors. This should then be combined with processes that elicit behavioural competencies that are aligned to creating a strength-based recruiting culture. Behavioural competencies should be weighted at least equally to technical competencies. Traditionally, too great a focus has been on technical competencies, resulting in employing desired technical skills at the cost of not having the right behavioural characteristics needed for organisational unity.

Behavioural interviewing may assist with recruiting individuals that can demonstrate essential resiliency protective factors such as social connectedness and social cohesion. Recruiting the right behavioural
characteristics is part of improving organisational culture. It is worth keeping in mind that potential employees with some deficits in technical skill may easily become the 'ideal' candidate with training support, whereas recruits lacking the right behavioural competencies are not necessarily remedied through training alone.

The Review team notes that, similar to comments made in the previous chapter, there is an 'unwritten rule' that recruits cannot fail the training. The Review team also heard of occasions where recruits were identified as clearly and consistently not being able to meet key targets, but instead of questioning whether MFB was the 'right fit' for them (and vice versa), significant pressure was put on the trainers to bring potentially unsuitable recruits 'up to scratch'. As the recruit training is the first significant investment in 'best fit' between the individual and the organisation, MFB would benefit from adopting a similar attitude to CFA, in which the recruit training is considered the final component of the recruiting phase.

8.2.2 Induction and resiliency training in non-leadership roles

Reducing stigma can be facilitated though incorporating mental health literacy in the induction process. This should also include education and training on key areas related to creating resiliency, which include;

- Nutrition and the role this plays in creating wellbeing and resiliency. MFB currently does not have a strong focus on the role of nutrition in health and wellbeing, and the Review team heard examples at station level of efforts to make inroads into this issue that have not been taken up at an organisational level.

- Exercise and the role this plays in creating wellbeing and resiliency. The fitness area and ESP have natural alignments. Both are invested in wellness and resiliency in complementary and interdependent ways. With the fitness area about to undertake a review process and establish a range of objectives, there is a timely opportunity to explore the relationship between to the two areas as part of reinforcing the importance of fitness in achieving both physical and psychological wellness and resiliency.

- Improving sleep and the role this plays in creating wellbeing and resiliency (as discussed in chapter three, Table two).

- Ongoing resiliency based education and training, including: Challenging Stigma; The Big Four – Goal Setting, Mental Rehearsal, Self-Talk and Tactical Breathing; Psychological First Aid (MANERS); Peer-based reflective space; mindfulness based stress reduction practices and; social connectedness (both within and outside of the work environment).

8.2.3 Induction and resiliency training in leadership roles

In leadership roles, familiarity with the content of non-leadership roles allows for valuing and supporting those staff not in leadership positions. For leaders however, the depth of the training, particularly in relation to the more operation specific resiliency skills should be modified to more of an overview.

For leaders, a greater focus should be on resiliency-based people management skills. Some of these skills should include: positive framing and supportive communication from recruitment to retirement; having a strength-based culture as 'how we do business'; reducing the tolerance bandwidth of unacceptable behaviours in the workplace; resiliency based training and promotion opportunities; regular genuine positive feedback as to what is going right and; reviews using techniques such as appreciative enquiry.
8.2.4 Resiliency based ongoing professional development

Good engagement processes that allow employees to exercise some control over their own careers acts as a protective factor. This approach also helps to identify opportunities for tailoring appropriate resiliency based training. For example, within the scoping processes for this report, Peers have expressed the desire for a range of resources to be developed to support their roles.

These include:

- Regular skill building sessions on common presenting issues including understanding and supporting those on WorkCover.

- The development of a mobile application for timely accumulation of statistics to inform service planning and the provision of training in the use of the application.

- Online training modules on key presenting issues (eg. sleep, Depression, Anxiety, resiliency, suicide awareness). These modules would facilitate those in shift rotations to access training and maintain their professional development.

8.2.5 Wellbeing checks and conversations

The Review team noted that there was occasionally confusion around the concepts of wellbeing checks and conversations. These need to be clarified across the organisation, as they are quite distinct processes.

- Wellbeing checks are a formal mental health screening process, undertaken by clinicians, which explore psychological distress and trauma experiences as well as protective wellbeing factors so as to give the individual an indication of "where their bucket is at".

- Wellbeing conversations can be formal or informal, although there may be times when both can occur simultaneously.

- Formal wellbeing conversations typically involve a line manager discussing issues of mental health and wellbeing, and possibly how this is impacting on the staff member's capacity to perform their work.

- Informal wellbeing conversations typically occur at a more collegial level and are more along the lines of 'mates looking out for mates'.

Throughout the careers of both operational and corporate staff it will be beneficial to have an ongoing process of voluntary wellbeing checks and chance for conversations both formally and informally and as part of professional development topics. This will help to reduce the likelihood of cumulative trauma through timely monitoring and coordinating appropriate preventative or, if required, treatment interventions.

As previously mentioned, regular processes such as these serve to facilitate the perception of support existing and also the provision of actual support through brief interventions, information resources and referrals.

The Review team is aware that approximately 400 MFB staff have now engaged in a wellbeing check and that demand for this service is growing. These processes need to be resourced in a manner that enables them to be regular to model a commitment to wellbeing. As a regular process they will also prove valuable if tied to effective and consensual data collection processes that can then be used to inform service planning.
8.2.6 Stay / return to work support, including WorkCover processes

- As discussed earlier, the Review team has noted significant concerns regarding the lack of coordinated planning and care for staff with psychological injuries. More needs to be done in this area, and could involve the following:

- Increasing mental health literacy as a strategy to facilitate the ability for employees to remain at work as part of their recovery process. In some circumstances this may be at normal capacity, and in other situations this may be with modified duties.

- As part of assisting employees to stay at work, particularly in relation to exposure to traumatic events, effective debriefing process that enable ‘post traumatic growth’ will need to be made available. This will require access to appropriately trained staff.

- Adopting a case management approach to allow for coordinated planning and care (including collaboration with external treatment providers such as the Brigade Medical Service).

- Upskilling the Peer Support Officers in the WorkCover process to aid their role in supporting colleagues.

- Acknowledging that the WorkCover process can cause secondary psychological trauma to individuals who are already suffering, and mitigating this risk as best possible (eg. providing specialised Peer support).

- Developing and disseminating specific psychological injury and career altering (eg. pregnancy duties, parental leave) literature, in order to help people understand and navigate the relevant systems.

- MFB may also benefit from looking at career break options. As covered in the opening section, the unique combination of stressors that exist for first responders can take a toll. Career-breaks and alternative duties allow for greater staff retention and this saves the organisation the costs associated with re-recruiting, training and the loss of organisational intelligence. However, it must be noted that – with this issue – concern was raised with the ‘cost’ of having a person involved for extended time in activities that might not be meaningful to the ‘injured’ employee.

It is rarely helpful to remove the person from the work situation altogether. Such an approach creates problems in terms of daily activity scheduling and makes rehabilitation and return to work harder. Rather, an opportunity to perform a different (non-frontline) role at work provides access to organisational and collegiate support, daily structure, and a sense of self-esteem that can greatly facilitate recovery (Phoenix, 2013).

8.2.7 Post service and retirement

Whether leaving the service as part of a career progression/ change or as part of retirement, inadequate support and preparation can result in detrimental effects to employees’ wellbeing and a lowering of their resilience. This can be due to a number of factors such as loss of role/identity, isolation, loss of a sense of purpose, feeling less secure including financially and deteriorations in physical and emotional health (including substance abuse).

Resiliency-based training and support helps to plan and monitor for these risks and to identify protective factors and how to maintain and enhance these. Planning can be undertaken for career changes and also retirement. In this planning phase, mental health and resiliency screening and the provision of supports such as access to peer support, social events, information, resources and referrals can be incorporated into a resiliency approach to exiting the organisation. Linking these services in with physical health and fitness is also going to be integral to wellbeing.
The Review team notes with interest that Victoria Police and Ambulance Victoria have Retired Peer Support models and suggests that MFB consider the applicability of such an investment as part of their overall Peer development process.

8.3 Wellbeing and resiliency communications and visibility

An essential component of a comprehensive and well integrated Mental Health and Wellbeing Strategy will relate to the use of communications to reinforce messages relating to mental health, wellbeing and resiliency. These areas will need to become a highly visible and be a regular part of MFB communication strategies as part of “how we do business”. This is especially important to facilitate the protective factor of creating the ‘perception’ that wellbeing is important within the organisation and that support exists. Creating perception is a different protective factor than that of providing ‘actual’ support with both ‘actual’ support and ‘perception’ of support being complementary.

8.4 Recommendations

25. Further development and implementation of the DRAFT MFB Mental Health and Wellbeing Plan is required.

26. Consistent with the beyondblue Good Practice Framework, it is now appropriate for MFB to develop a more holistic employee lifecycle health management approach that integrates existing initiatives into a more coherent whole of career focus. Specific recommendations could include:

- A greater focus on resiliency screening during the recruitment process.
- Formalised resiliency training during induction training.
- Specialised resiliency and leadership training for those in leadership/managerial roles.
- Continue to expand wellbeing checks and conversations (see chapter six).
- Significant investment into achieving best practice injury management practices (see chapter six).
- Consider career break opportunities and increased support for those unable to stay in their operational roles.
- Increased focus on retirement screening and support services.

27. Executive leadership and organisational championing is required to integrate resiliency across MFB.
### APPENDIX 1: DRAFT MFB Mental Health and Wellbeing Plan overview

<table>
<thead>
<tr>
<th>Strategic objectives</th>
<th>Priority actions</th>
<th>Resourcing requirements</th>
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<tbody>
<tr>
<td>1. Promote and support mental fitness within MFB</td>
<td>1.1 Refreshing Employee Support communication approaches and materials</td>
<td>Development of an Employee Support Newsletter</td>
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<td>1.2 Increasing organisational mental health training options</td>
<td>Resilience focused clinicians/trainers to deliver training and education</td>
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<td>1.3 Addressing stigma and barriers to care</td>
<td>Mental Health First Aid</td>
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<td>1.4 Development of a 'whole of career' resilience-based training framework</td>
<td>Suicide Awareness</td>
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<td>2. Identification and response to mental health risks of MFB emergency service work</td>
<td>2.1 Increasing organisational awareness of mental health issues</td>
<td>Organisational wellbeing check clinician</td>
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<td></td>
<td>2.2 Strengthening the mental health screening continuum</td>
<td>Clinical and organisational supervision of the Peer Support Program</td>
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<td>2.3 Enhancing the Peer Support network</td>
<td>A second Peer Support Coordinator</td>
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<td>2.4 Enhancing of reporting mechanisms for mental health concerns</td>
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<td>3. Delivery of comprehensive, coordinated, customised mental health care</td>
<td>3.1 Improving pathways and access to care</td>
<td>An 'app' to allow for recording and activation of support mechanisms</td>
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<td>3.2 Development of targeted mental health and wellbeing services</td>
<td>Increased intranet functionality to direct help-seeking processes</td>
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<td>3.3 Development of recovery oriented processes and practices</td>
<td>Cumulative trauma and co-morbid symptom specialist clinicians</td>
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<td>The use of an Actuarial Statement regarding mental health issues within the workplace, in order to inform planning for internal service responses</td>
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<td>Strategic objectives</td>
<td>Priority actions</td>
<td>Resourcing requirements</td>
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<td>4. <strong>Continuously improve the quality of mental health care</strong></td>
<td>4.1 Development of data collection and analysis platforms for MFB mental health services</td>
<td>An externally housed Critical Incident Data Platform</td>
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<td>4.2 Refreshing the Peer Support training and role development process</td>
<td>An externally housed patient care database</td>
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<td>4.3 Systemic review of Employee Support training services</td>
<td>Use of client satisfaction ratings and outcome measures with EAP provider</td>
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<td>5. <strong>Strengthening strategic partnerships and strategic development</strong></td>
<td>5.1 Engaging with other emergency service agencies in whole of service/whole of organisation discussions</td>
<td>A strong and pervasive values and expected behaviour piece is a central element of first responder organisation good practice: this includes accountabilities at all levels</td>
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<td>5.2 Increasing organisational awareness of national/international standards and practices</td>
<td>People-centred leadership practices are also required at all levels</td>
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**APPENDIX 2: ESP Review - Terms of Reference**

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<tr>
<th>Terms of reference point</th>
<th>Summary findings and reference within Review document</th>
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<tr>
<td>1. Assessment of current Employee Support Program (ESP) processes, policies, and procedures.</td>
<td>Broadly speaking, the ESP processes are well received and reflective of industry best practice. However the resourcing to provide comprehensive best practice is inadequate and the service struggles to meet the increasing demand. The policy and procedural documentation is also in line with best practice but is significantly outdated and needs to be refreshed and ideally better resourced in moving forward. Chapter four – ‘Current ESP service profile’ unpacks the ESP in detail, whilst chapter eight – ‘Resilience across the lifespan’ unpacks the ‘bigger picture’ service approach.</td>
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<td>2. Review the DRAFT MFB Mental Health and Wellbeing Plan (2016 – 2018) against available best practice, and make recommendations regarding priorities, resourcing and planning</td>
<td>The Action Plan meets national and international best practice standards and is in line with key wellbeing and resiliency frameworks. However resourcing restrictions mean that operationalisation of this Plan will be challenging, given current ESP structure. Chapter four – ‘Current ESP service profile’ Strategic snapshot unpacks this in more detail and makes recommendations regarding priorities, resourcing and planning. These recommendations should also be paired with the recommendations from chapter five regarding mental health literacy, and chapter eight regarding holistic service delivery.</td>
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<td>3. Assessment of the scope of support and professional supervision that is provided to the clinicians, professionals and internal peers who provide services to the MFB workforce.</td>
<td>The current resourcing of the ESP means that adequate support and supervision is not provided to key ESP staff, in particular the Peer Support Officers. Chapter four – ‘Current ESP service profile’ unpacks this within the service delivery and Peer Support Program sections.</td>
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<tr>
<td>Terms of reference point</td>
<td>Summary findings and reference within Review document</td>
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<td>4. Where possible, benchmark of ESP against comparable support models provided in similar emergency services and trauma-response organisations and service delivery settings.</td>
<td>Truly meaningful benchmarking of MFB against other emergency services is not possible. However some basic comparisons with relation to Peer and clinician ratios are made in chapter four – ‘Current ESP service profile, service comparisons’. Chapter four – ‘MFB mental health profile’ also broadly discusses the mental health and wellbeing issues within MFB comparable to other services.</td>
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<td>5. Assist with the mapping of service and program pathways, including both internal and external service providers.</td>
<td>Issues of coordinated referral and care are noted as being ad hoc, both within MFB (eg. between the ESP and WorkCover team) and outside MFB (eg. with the EAP). Chapter six – ‘Occupational Health and Safety, OH&amp;S performance and WorkCover’, and Chapter eight – ‘Resilience across the lifespan’, talk to these issues. Both chapters make recommendations regarding better service planning and integration.</td>
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<td>6. Make recommendations for ongoing evaluative processes of specific programs within Employee Support to help ensure optimal ongoing quality and effectiveness, including suggested resourcing.</td>
<td>Overall, the specific Employee Support program areas are aligned with best practice. They would benefit from additional resourcing, which is documented throughout this Report. Once this has occurred, evaluation would be more helpful in terms of undertaking a continuous quality improvement approach. Specific resourcing recommendations are made at the end of chapter four ‘Current ESP service profile’, chapter five regarding mental health literacy, and chapter eight regarding holistic service delivery.</td>
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APPENDIX 3: Key findings

3.1 Key findings - MFB mental health profile

- Post Traumatic Stress Disorder (PTSD) is not the only mental health risk within the MFB: other mental health issues (such as Depression, Anxiety, and substance use disorders), are prevalent and appear to be increasing.

- Work related distress (as distinct from trauma exposure during EMR and Critical Incidents) is having an increased effect on mental health and wellbeing.

- Suicide risk is difficult to accurately appraise, but is thought to be higher in Emergency Services generally than in the general population, and is of significant concern given the recent increase in deaths by suicide of MFB staff.

- The uptake and engagement of the organisation in mental health and wellbeing screening (the "Wellbeing Checks") has been significant and positive to date, and continues to expand.

- Issues of wellbeing (as opposed to mental ill-health/illness), as identified during Wellbeing Checks, indicate that areas of 'feeling respected' and 'having a sense of meaning and purpose in daily activities' present opportunities for organisational improvement.

4.1 Key findings - Current ESP service profile

- Overall the ESP is well regarded within the organisation.

- The current developmental initiatives produced by the ESP create the potential for achieving best practice.

- The Review team identified a number of current shortcomings that need to be addressed to implement the developmental initiatives.

- Resourcing to deliver ESP is outdated and is based on a narrower scope of service delivery and a historically lower level of demand.

- Inadequate documentation relating to service delivery and data capture for service planning was noted.
5.1 Key findings - Mental health literacy and stigma in MFB

- Current mental health literacy and stigma reduction initiatives across MFB are somewhat ad hoc and lacking in reach and coordination.

- There is a need to increase and better coordinate mental health literacy and stigma reduction initiatives, with the goal of increasing earlier employee help-seeking behaviour.

- The most common form of mental health stigma observed across MFB is avoidance or delay in help-seeking due to feelings of embarrassment or shame (eg. 'self-stigma').

6.1 Key findings - Occupational Health and Safety

- There is a lack of organisational systems to monitor and proactively address the possible effects of cumulative incident exposures. This is a major organisational psychological health and safety risk that needs to be urgently addressed.

- EMR is another area of organisational psychological health risk also related to the potential effects of workplace trauma/cumulative exposures.

- There is currently insufficient matching of ESP initiatives according to MFB's risk profile; i.e. directing more initiatives according to risk levels, eg. stations that perform relatively higher levels of EMR.

- The current MFB occupational health and safety and workers compensation performance is extremely poor when benchmarked against all relevant industry standards.
7.1 Key findings - MFB organisational culture and contextual factors that influence employee mental health and wellbeing

- The Employee Support Program is generally regarded as being neutral and positioned outside of the ongoing polarising MFB industrial relations challenges.

- However, there are certain unique MFB cultural features that do inhibit appropriate help-seeking behaviours and timely access of mental health services.

- In terms of MFB culture, stations are characterised as family like tribal sub-cultures that are highly supportive but not necessarily inclusive.

- This type of sub-culture tends to shield and hide physical and mental health risk.

- The ongoing industrial relations disputation and media coverage is associated with declining morale and increasing psychological health and safety risk.

- The extreme lack of MFB workforce diversity, lack of mobility and access to flexible working hours contributes to psychological health and safety risk. Improving these factors would contribute towards improving mental health and wellbeing outcomes.

- From a mental health and wellbeing perspective, the current VEOHRC Review is considered to be very important for the future of MFB.

- There is an excessively wide tolerance margin for inappropriate behaviours across the MFB and this directly contributes to psychological health and safety risk.

- There appears to be a lack of appropriate accountabilities, skills and sometimes motivation, among leaders to appropriately address behavioural issues.

8.1 Key findings - ‘Resilience across the lifespan’

- While widely accepted in principle, a ‘whole of lifespan’ approach has yet to be formally and successfully implemented across MFB.

- A ‘whole of lifespan’ approach is hampered by organisational structure issues such as resourcing constraints and unintentional silo-ing between teams/ departments.
APPENDIX 4: Recommendations

3.4 Recommendations - MFB mental health profile

1. There is a need for more accurate prevalence data to establish a baseline profile to clarify the precise extent of mental health (including substance use/abuse) and suicide risk. Such prevalence data could also be used to fine-tune future mental health and wellbeing initiatives, as well as evaluate the effectiveness of the mental health strategy. Therefore, the MFB’s active participation in the beyondblue national prevalence study (to be implemented in early 2017) regarding emergency services mental health is recommended.

2. Mental health literacy initiatives (including Mental Health First Aid and suicide awareness training, as well of issues of trauma, vicarious trauma, burnout and cognitive impairment) should be prioritised for MFB staff in key leadership, managerial, and occupational areas. This will be discussed further in chapter five, along with resourcing recommendations for the ESP to deliver this service in chapter four.

3. It is also recommended that the MFB develop a cumulative suicide register and undertake ‘psychological post mortems’ after the death by suicide of MFB staff (as practiced by Victoria Police and other agencies) to build organisational knowledge and help identify any common risk factors. This process essentially involves a clinical analysis to identify risk and causal factors associated with within the deaths by suicide, and implementation of learnings to attempt to negate future risk. While obviously a reactive measure, this allows for the reflection and implementation of any best practice issues not currently being enacted (as per the National Suicide Prevention Strategy, Living Is For Everyone, 2016).
4.14 Recommendations - Current ESP service profile

As the ESP was initially resourced with a more direct service delivery role and with substantially fewer peers, it is timely to review and update resourcing in line with service demand and current best practice. The Review team therefore recommends an increasing of the ESP FTE to implement the Mental Health and Wellbeing Action Plan. This is mirrored, at least in the area of PTSD, in the Fire Services Review (2015) where it noted that “Post Traumatic Stress Disorder (PTSD) is a feature of emergency services workforces across the globe. The fire services must ensure that their existing programs are sufficiently robust to provide appropriate levels of support” (p. 39).

These recommendations are detailed in the accompanying Business Case, and include the following:

**Staffing**

4. A second FTE Peer Support Coordinator (a review of pay structure is also recommended, to make the role more attractive to operational staff who might otherwise experience a reduction in pay to take on this role).

5. With regard to clinical services, five FTE employees (clinicians and/or trainers) to assist with the provision of mental health screening, training and education, triaging and clinical support services (including clinical supervision of Peer Support Officers), as detailed earlier in this chapter. This could commence with two clinicians, as discussed earlier in the Timeline recommendations; however it is anticipated that five would be required to deliver 'best practice', to recoup the projected WorkCover savings (detailed in chapter 6), and to accommodate the potential increase in mental health service demands.

**Resourcing**

6. An externally housed critical incident database is required to manage organisational risk issues, and to document operational response processes to MFB critical incidents (along the lines of the Tasmanian and Queensland models).

7. Electronic resourcing for confidential storage of mental health documentation, such as Wellbeing Checks, internal clinical notes, and other related materials (eg. external contractor notes).

8. Resourcing dedicated to the development of targeted resilience and wellbeing information, comparable to the Department of Defence High Res App/website, in order to assist Employee Support staff in the roll out of training and maintenance of resilience and wellbeing strategies.

**Other recommendations**

9. Scope be granted for the Employee Assistance Coordinator to review the DRAFT MFB Mental Health and Wellbeing Plan, and strategically plan its implementation.

10. Undertake an audit of ways in which ESP is notified of mental health and wellbeing concerns, as well as program responses.
5.3 Recommendations - Mental health literacy and stigma in MFB

11. Review and update existing mental health education and awareness content (including suicide awareness content) with consideration to consulting an external subject matter expert. Organisational investment in a comprehensive mental health literacy and stigma reduction program is a cost effective way of improving mental health and wellbeing outcomes: earlier help-seeking reduces levels of disruption to employee functioning and reduces downstream treatment costs.

12. Develop an organisation-wide mental health literacy strategy involving multiple delivery modalities including peer presentations, clinician presentations, online resources and embedding content in leadership training programs.

13. Expand the triage process with the external EAP provider to increasingly match presenting employees with the most appropriate counsellor. This process should be undertaken by the Employee Assistance Coordinator, or clinical staff within the ESP.

14. Organisational leader role modelling and ‘champions’ should be supported and developed to ensure program effectiveness via a ‘top down’ approach.

6.5 Recommendations - Occupational Health and Safety

15. As a matter of priority, MFB needs to implement a structured case management and case planning approach to dealing with staff who are psychologically injured (this includes those who are on light/altered duties, those who are on variations of ‘sick leave’ and those formally engaged in the WorkCover process).

16. An organisational system for tracking cumulative exposure and associated psychological risks needs to be developed as a matter of urgency, to support the development of a more proactive contact regime with employees with higher potential levels of psychological risk.

17. MFB needs to develop an organisation-wide psychosocial risk register to guide the proactive targeting of mental health and wellbeing initiatives.
7.5 Recommendations - MFB organisational culture and contextual factors that influence employee mental health and wellbeing

18. It is imperative for achieving organisation-wide improvement in mental health and wellbeing outcomes, as well as suicide prevention, that key stakeholders work together collaboratively (i.e. the Senior Leadership Team and the Union). The Review Team recommends that renewed efforts be made in this direction.

19. It is recommended that the process of increasing workforce diversity, access to flexible working hours and increased mobility continue, and be accelerated, as this will directly contribute towards achieving overall improvements in employee mental health and wellbeing.

20. The VEOHRC Review should be fully supported and embraced as it will also have important implications for the mental health and wellbeing of all MFB employees.

21. The option of a mandatory fitness for duty assessment process should be developed and positioned as an organisational early intervention tool to minimise risks to individual, organisational and public safety. This should include medical and psychological fitness for duty assessments.

22. That the drug and alcohol screening regime, scheduled in the MFB Always Safe Action Plan for 2016-2017, be prioritised and developed to include options for random and targeted screening.

23. In addition to the current employee behaviour training program currently being implemented, it is recommended that manager accountabilities at all levels be clearly re-defined and implemented and that manager training in proactively addressing behavioural issues be developed and implemented.

24. Finally, it is recommended that the Senior Leadership Team consider investing in people-focused leadership training and development. Further reading with regards to operationalising this action can be found in the Victoria Police Mental Health Review (2016), as well as the Department of Defence document Pathway to Change – Evolving Defence Culture (2012).
8.4 Recommendations - 'Resilience across the lifespan'

25. Further development and implementation of the DRAFT MFB Mental Health and Wellbeing Plan is required.

26. Consistent with the beyondblue Good Practice Framework, it is now appropriate for MFB to develop a more holistic employee lifecycle health management approach that integrates existing initiatives into a more coherent whole of career focus. Specific recommendations could include:

- A greater focus on resiliency screening during the recruitment process.
- Formalised resiliency training during induction training.
- Specialised resiliency and leadership training for those in leadership/managerial roles.
- Continue to expand wellbeing checks and conversations (see chapter six).
- Significant investment into achieving best practice injury management practices (see chapter six).
- Consider career break opportunities and increased support for those unable to stay in their operational roles.
- Increased focus on retirement screening and support services.

27. Executive leadership and organisational championing is required to integrate resiliency across MFB.