COMMUNITY DEVELOPMENT AND JUSTICE STANDING COMMITTEE

MANAGEMENT OF POST-TRAUMATIC STRESS DISORDER

TRANSCRIPT OF EVIDENCE
TAKEN AT PERTH
WEDNESDAY, 3 APRIL 2019

Members

Mr P.A. Katsambanis (Chairman)
Mr M.J. Folkard (Deputy Chairman)
Mr Z.R.F. Kirkup
Mr A. Krsticevic
Mr D.T. Punch

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Hearing commenced at 9.48 am

Ms SUSAN JONES
Assistant Commissioner, Mental Health Commission, examined:

Ms JUDI STONE
Acting Director, Prevention Services, Mental Health Commission, examined:

The CHAIRMAN: Thank you for agreeing to appear before us today. My name is Peter Katsambanis and I am the Chair of the Community Development and Justice Standing Committee. The other members are the Deputy Chair, Mark Folkard; Zak Kirkup, the member for Dawesville; Don Punch, member for Bunbury; and Tony Krsticevic, member for Carine. It is important that you understand that any deliberate misleading of this committee may be regarded as a contempt of Parliament. Your evidence is protected by parliamentary privilege; however, the privilege does not extend or apply to anything that you might say outside of today's proceedings. Are you able to introduce yourselves and the capacity you appear in for the record, please?

Ms Jones: My name is Sue Jones, I am the assistant commissioner at the Mental Health Commission. My portfolio looks after the alcohol, other drugs and prevention services. That also includes the statewide suicide prevention strategy 2020. I also have the clinical service arm of the organisation, which is the Next Step detox inpatient and outpatient unit.

Ms Stone: My name is Judi Stone. I am the acting director of prevention services. I look after workforce development, which is alcohol and other drug-related workforce development; Strong Spirit Strong Mind Aboriginal programs, which is another workforce development program; alcohol and drug support services, safe and healthy settings, which is around campaigns and safer settings; the alcohol program, which is around liquor licensing; and—I am just trying to think who else.

Ms Jones: Community programs.

Ms Stone: Community programs, who develop alcohol and other drug management plans, but also coordinate the suicide prevention coordinators around the state.

The CHAIRMAN: Thank you. Do you have any questions about your appearance here today?

Ms Jones: No, I do not think so. We have been pretty well briefed, thank you.

Ms Stone: No.

The CHAIRMAN: Excellent. What we are doing is we are scoping out whether we need to delve into having a broader inquiry into the management of post-traumatic stress disorder across the WA public sector, in particular in emergency services—first responders and the people who sit behind them. We thought, as the Mental Health Commission for WA, you would be people who would be well placed to give us some information that will then help us to determine what the landscape is like in the area and whether we need to delve any further into it. That will be the context in which we will be asking questions today. Did you guys have any opening statements, or do you want us to go straight into questions?

Ms Jones: No, I think that is fine, if that is okay.

The CHAIRMAN: Perhaps I will start by asking if you can give us a bit of a brief overview of the work of the Mental Health Commission in relation to post-traumatic stress disorder, and how you interlink or relate with the various agencies that would have staff that might be subject to PTSD.

Ms Jones: Really, the work of the policy division in developing the plan—the full title is the "Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015–2025"—that really is our roadmap in terms of the services and the service reconfiguration. The Mental Health Commission wants to work with other agencies to actually reconfigure mental health services across the state. That is through the full spectrum, from acute care to mild and moderate and the prevention space. It does not specifically mention PTSD. Where PTSD would be covered would be in people who just need to access mental health services, whether that is in the acute trauma side or whether or not it is in GP prevention. That is really our role in determining the mental health services across the state. I suppose we assist agencies when agencies want support in perhaps how they can implement wellness across the organisation. I can talk to you further about workplace health and what we are doing in that space, but the commission cannot—basically, it does not have powers to instruct agencies about how or what they do with their own individual staff in the space of PTSD. We do not have a jurisdiction to actually do that.

The CHAIRMAN: Do you have resources that you could provide or can be accessed in relation to PTSD, or is your remit a bit broader than that?

Ms Jones: It is broader, I think. PTSD is sort of a small but very important component of injuries that employees would get in the workplace, but would definitely be more specific for a first-responder organisation, as you would know, which is the police, the ambos—so those sorts of organisations, be it Justice, WAPOL. Certainly that is their core function; it is not the core function of the Mental Health Commission. But what we do as part of the suicide prevention 2020 strategy—we have actually pulled together a first responders working group. The first responders working group actually came out of recommendation 11 in the report "The Toll of Trauma on Western Australian Emergency Staff and Volunteers". The recommendation stipulates —

The Ministers for Health, Police, and Emergency Services ensure that the Western Australia Police, the Fire and Emergency Services Authority and St John Ambulance establish a formal platform to share their knowledge and experience in delivering programs to their staff and volunteers to address issues of stress from disasters and critical incidents, as is done in other Australian jurisdictions.

The first responders working group was actually coordinated and initiated from the Mental Health Commission in 2016. The members of that working group are from the police force; the Department of Justice, previously department of corrections; St John Ambulance; FESA; and the Department of Biodiversity, Conservation and Attractions, which was formerly the department of parks. That first responders group actually comes together and they meet bi-monthly. The purpose of that group is for the members of the agencies to really—it actually gives them a real opportunity to leverage new and existing work initiatives. They will actually come together as peers. They spent a couple of years looking at what they each do in terms of their organisations. They are all a little bit different—police from correctives, St Johns—but they all are first responders.

Mr M.J. FOLKARD: What rank are those officers who attend?

Ms Jones: Quite senior, but also representing the health and wellness side of the arm.

Mr M.J. FOLKARD: So what rank? Can you define it? By "senior", are they deputy commissioner level?

Ms Jones: No, not deputy commissioner level.

The CHAIRMAN: Could we possibly get from you a list of the people who attend?

Ms Jones: Absolutely.

The CHAIRMAN: I am not sure if you can, but if you can, can you give us some minutes of the meetings so we can get a flavour of it?

Ms Jones: Yes. I will probably just need to check with the other organisations that they were happy, but I do not think that would be a problem.

The CHAIRMAN: We will record that as two separate things. Give us a list of the job titles, if you like, of the people who attend the meetings, and then if you can provide us with some minutes from the meetings, that would be helpful as well.

Ms Jones: Sure.

The CHAIRMAN: So this group meets bi-monthly?

Ms Jones: It does.

The CHAIRMAN: Is it coordinated by the Mental Health Commission?

Ms Jones: It is coordinated.

The CHAIRMAN: What is your role in this?

Ms Jones: The staff from my directorate actually coordinate the meeting, so provide the executive support. The group actually shares the chairing of the meeting. They are able to then share resources amongst themselves, so if one organisation needs some information about this, the other organisations would help. St Johns was quite integral as an early member of part of that group. I do recall —

Mr M.J. FOLKARD: Is that because of the cluster of suicides that they had?

Ms Jones: No, it just came out of that one recommendation that responders needed to actually come together as organisations and actually be able to work out how they best look after their staff and leverage new initiatives. The commission actually was integral in setting that group up and actually providing support to the group. The group stated that they felt it was really important that the Mental Health Commission was independent from the other organisations and was able to basically ensure that it continued, and that they get great value from the actual meeting. I can definitely provide that information for you.

The CHAIRMAN: Thank you. So you do not actually provide the resources yourself: you are a forum to allow the various other groups to share information amongst themselves.

Ms Jones: Correct.

The CHAIRMAN: I know you have been working on something called the Thrive at Work program.

Ms Jones: Yes.

The CHAIRMAN: Where is that?

Ms Jones: Where is it based or where is it at in terms of the project?

The CHAIRMAN: Where is it at?

[10.00 am]

Ms Jones: So, the Thrive at Work project actually also came out of the suicide prevention strategy. The suicide prevention strategy, one of the six action areas—I am happy to provide all this information to you—in the strategy says that there should be a shared responsibility across government, private and non-government sectors, to build mentally healthy workplaces. That was the inception of the actual drive. What we did, we are a foundational partner with the Centre for

Transformative Work Design. Initially, that organisation was placed in UWA. It has consequently moved over and is affiliated with Curtin University. We partnered with the centre a couple of years ago, and we have been working with them, as I say, as a foundational partner to actually develop a tool and a framework that all organisations can actually tap into, whether it be mining, whether it be private, whether it be small or large organisations. Depending where they are in terms of their maturity, then they can gain assistance to better look after and care for their employees.

There is going to be a launch of Thrive on 16 May, so it is actually formally going live with a website and everything, and there is going to be a number of organisations that will be invited to that. The building blocks for Thrive are really based on the fact that a lot of organisations currently are able to tick the box for occ health and safety and policies within their organisations that they can actually use, but for Thrive the basis is to move organisations through it to become much more of a positive, mentally healthy workplace where staff feel safe, that they feel they can do their job to the very best of their ability, that they are supported by the organisation, they are supported by managers who are well trained to be able to look out for staff who are unwell in the workplace, that the managers can actually recognise. I know in some of the reports they talk about there should be mandatory, compulsory training for managers so they can actually recognise and be trained in things like mental health first aid or assisting the suicide prevention space.

Mr M.J. FOLKARD: Is this specifically targeted at suicide related to the workplace or is this about creating cultural change within the workplaces so they actually value people who are going through these emotional times?

Ms Jones: It is all of it. It is a full spectrum from working through the healthy, prevention, thriving space through to making sure that if anyone is quite unwell, they are in a good environment.

Mr M.J. FOLKARD: I will pull you up on that. I met with a Professor David Clark over in the UK in December. No one in Australia at the moment is doing any research in relation to the preventions in relation to PTSD. You are saying preventing it in the workplace. How can that be? That is a complete contradiction.

Ms Jones: I think the prevention in the workplace comes from if you have a safe environment and your staff feel quite well and supported, that is just one pillar that works towards a prevention of an unwellness over time.

Mr M.J. FOLKARD: We just went through the St John's inquiries where they said that they had a toxic work culture which led to some of these workplaces. That was one of the key findings in relation to those inquiries. Are they engaged in this space? How do we know? Are there any quantifiable statistics coming out from preventions or what they are looking at?

Ms Stone: I think there is a lack of research evidence around what is effective in preventing post-traumatic stress in the workplace. Certainly, the research I have looked at in preparation for this hearing suggests that there is not a lot of good studies that actually show what works.

Mr M.J. FOLKARD: There are three going on at the moment. One is in the UK, one is in Canada, the other one is in the United States.

Ms Stone: Yes, and that is great because we need that evidence to determine what works well. One thing that several of these studies has said is that a supportive work environment actually helps people who experience post-traumatic stress disorder return to work more quickly and an environment where managers are trained and colleagues are supportive and the workplace values their staff is something that can assist people recover faster from post-traumatic disorder related to work injuries, work experience.

The CHAIRMAN: As a commission, you fund research, do you not, or you collaborate with other research partners?

Ms Jones: Yes.

The CHAIRMAN: Have you funded or collaborated in any research specifically towards post-traumatic stress disorder?

Ms Jones: Not specifically towards PTSD, no, but research has been funded recently into the work that was done around the FIFO inquiry. That was funded, and also this Thrive at Work Strategy was also funded as well.

The CHAIRMAN: I do not want to put words into your mouth, but the Thrive at Work Strategy, as you have described it, that is about to be launched in the next few months, it appears to be more a top-level awareness campaign so that people can find out some of the signs and what to look for in their work colleagues or their staff, rather than a detailed and descriptive, almost a how-to guide on what to do when you get there; would that be right?

Ms Jones: I think the resources that are contained in the Thrive framework will be detailed enough to allow organisations and first responders to go and get the latest, most evidence-based research that there is to take back to their organisations, depending on where they are. Some organisations are more mature than others; some actually do now do mental health training across their organisations. Certainly, the Mental Health Commission wants to walk the talk in this space and we do have mental health first-aiders in the organisation who are trained to actually be there and support both employees and employers. I think this is a start and a framework that—we are actually very well advanced in WA to assist the organisations with somewhere to go because often organisations say, "We sort of know, we think we know what we have to do, but we do not know kind of where to go and we need support and we need help to do that." So, there is a willingness, generally, in the agencies to really want to support. But it also goes to the culture of individual organisations as well. Some cultures are quite different. When you look at, say, police, some of the first responders were command and control–type cultures. I think there has been evidence in some of the previous reviews that have actually said that those cultures can be quite difficult for staff to actually say that they are struggling, say they have problems, because they do not feel supported in that workplace to actually do it, that they feel that they are —

Mr M.J. FOLKARD: They actually get ostracised when they do.

Ms Jones: Ostracised, stigmatised, fear of losing their job.

Mr M.J. FOLKARD: Career destroying, and we will keep going down the line.

Ms Stone: Yes. Definitely. One thing we have done at the Mental Health Commission is develop and deliver a trauma-informed care and practice workshop which is open to all human service providers irrespective of their role. They could be an administration officer or they could be a CEO or a counsellor. That is a workshop that runs for a day. It is free of charge on our training calendar and so far we have provided it to around 330 participants, and that is since late 2016. That actually looks at organisational culture and practices which are trauma-informed, meaning that it is for the benefit of the clients as well as for the benefit of the staff. It is based on the principles of trauma-informed care and practice around safety, around recognising culture gender and historical factors which might impact on clients or staff. It is also about consultation and sharing of power, trustworthiness, collaboration.

Mr M.J. FOLKARD: Is that about cultural change within organisations?

Ms Stone: Yes, some of it is. Some of it is about individual practice. The principles can be applied to individual practice. They can also be applied to organisational culture. As part of that training, we provide—people who attend with a link to an agency self-assessment tool which can assess, help the agencies determine whether they are trauma-informed and look at practices.

Mr M.J. FOLKARD: Has there been any follow-up in relation to participants who have participated in the course, as to what they have been able to take away, have they been able to embed that training into those organisations, and what has been the outcomes from those?

[10.10 am]

Ms Stone: Only anecdotal feedback. For example, we delivered the training to Wandoo staff and the feedback we received from the senior staff who were present at the training was that they are very interested in delivering trauma-informed care and practice at other Justice-type sites, and that they felt it helped them to develop a very good understanding of where the residents in Wandoo came from and some of the issues affecting them, but also to help understand their own issues that have come up in relation to trauma in their work roles and in their life histories. They have actually adopted those principles in terms of some of their practices with the residents. For example, if they are doing a cell search, they will actually, within the limits of what they have to do in their role, say to the residents, "Would you like to remain in the room or would you like to go out of the room while we conduct a cell search?" So it is a small thing, but it is a change in mindset in terms of how the staff treat the residents at Wandoo.

Mr M.J. FOLKARD: Is this about enhancing the residents at Wandoo or is this about looking out for the staff?

Ms Stone: Both, because if people understand how trauma can affect people, whether they are clients of a service or people on the street or family members or colleagues, it affects how they respond to those. They tend to respond more with compassion and support than that sort of ostracising and judging.

Mr M.J. FOLKARD: So that is about using the trauma counselling role embedded into their workplaces?

Ms Stone: This is not about trauma counselling; this is about teaching people about what trauma is and how it can affect people. So the difference between trauma-informed care and practice and trauma therapy is that trauma therapists is a specialised service whereas trauma-informed care and practice can be done by any organisation.

The CHAIRMAN: In that trauma therapy space, is there a list of people who are available? Can someone contact the Mental Health Commission and get those sorts of lists of people?

Ms Stone: We are actually in the process of launching an organisation community directory, an online community directory.

Ms Jones: I think there is a lot of training that is available to people in different spaces depending on what the organisation actually needs. Certainly, we are available to assist organisations if they ask, "What sort of training would you recommend? Do we need the two-day mental health training or is it the assist suicide?" There is a lot of training available. The other thing we have been able to do, again, as part of the suicide prevention strategy is we have provided quite a number of grants over the last three years to communities and to the 10 suicide prevention coordinators that are across the regions. That is enabling the community to really upskill in these training opportunities, again, the mental health first-aid, so they can recognise in the community people who need help. It is also about empowering the community. Often people struggle and say, "Well, I have a family member who may have PTSD", or farmers, regional men who are struggling, whatever the issue is,

and they are not actually sure what to do or how to recognise so they do not call it out. Part of the training as part of the suicide prevention strategy has been to roll out extensive training where possible to enable people to be skilled to recognise and support people.

The CHAIRMAN: Are you able to provide us with a list of the community grants that you have provided, say, over the last three or four years?

Ms Jones: Yes.

Mr M.J. FOLKARD: In relation to the costings of treatment in relation to PTSD, is there a breakdown of that available as to how much we are currently spending in that space?

Ms Jones: I am not aware that it would be available in terms of PTSD.

Ms Stone: The difficulty is that often people with PTSD experience co-occurring conditions like substance abuse disorders or depression or anxiety.

Mr M.J. FOLKARD: Chronic illness, is that right? Untreated PTSD leads to chronic illness?

Ms Stone: Yes. So they often end up in other services.

Mr M.J. FOLKARD: Manifests itself in—yes.

Ms Stone: So it is difficult to sort of gauge. There are not specific PTSD services per se in Western Australia —

Mr M.J. FOLKARD: There is.

Ms Stone: —apart from AseTTS—Association for Services to Torture and Trauma Survivors—and —

Mr M.J. FOLKARD: No. Ramsay Health are delivering a trauma course at the moment that are specifically to first responders —

Ms Stone: I did not know that.

Mr M.J. FOLKARD: So that is not true.

Ms Stone: I beg your pardon.

Mr M.J. FOLKARD: We also know that we have approximately 60 000 first responders in the state and we know that current research says that as much as two in three of those particular individuals are suffering PTSD, so the question is: what investment are we doing in that space?

Ms Jones: I think it is very much individual to the organisations and how much they —

Mr M.J. FOLKARD: So we cannot quantify that?

Ms Jones: We could certainly go back to the commission and see if there is any evidence there or any information. I do not have it with me at the moment, but we could certainly ask.

The CHAIRMAN: Do you collect data in this space?

Ms Jones: Yes. We have an area within purchasing and contracting that looks after the data and does a lot of work actually in that space with the research areas to try and actually collate, wherever we can, good relevant data that can enable the commissioning and the procurement of services.

The CHAIRMAN: Again, perhaps you can take it on notice to look at that data and see what you can provide us in the space that we are most particularly interested in.

Ms Jones: Okay.

The CHAIRMAN: As Mr Folkard said, anecdotally, we hear about the statistics around two in three first responders showing some signs of PTSD, but it would be good to see some of the hard data around it.

Ms Jones: Yes. We will take that away and take that on notice.

Mr D.T. PUNCH: Two questions: given PTSD is recognised under DSM-5, is there a relationship with NDIS and PTSD?

Ms Stone: I believe there could be a relationship with PTSD and NDIS in terms of it is a mental disorder—psychosocial disorder.

Mr D.T. PUNCH: Do you know if there has been any analysis of what the likely implications of that could be, in terms of numbers?

Ms Stone: I do not know the answer, but we can try and find out.

Mr D.T. PUNCH: The other component in literature I have seen is that at various points there is a bit of a threshold, that areas such as child protection workers have come into scope. Is that something that is being considered within the Mental Health Commission?

Ms Stone: I am not sure I understand the question.

Mr D.T. PUNCH: In terms of the Thrive process and the interagency framework you described earlier it notes that the Department of Communities were not represented in that setting on the interagency forum, that child protection workers do seem to have, firstly, very high turnover, and, secondly, a number of express mental health symptoms. I am just wondering about that interface and whether, at a state level, there is some conversation happening in relation to that occupational group?

Ms Stone: There has not been, that I am aware of. You are correct, child protection workers do face incredible traumas and mental health workers do as well, and alcohol and drug workers.

Mr D.T. PUNCH: Is that something you would like to come back to us on, in terms of whether there is some activity happening, or is it your opinion that there is nothing happening in that space?

Ms Jones: I think that is probably a question specifically for that agency —

Mr D.T. PUNCH: All right.

Ms Jones: Rather than the Mental Health Commission trying to answer on behalf of the agency, I think it is important that it goes directly to that agency.

Mr D.T. PUNCH: Is it the Mental Health Commission's role to raise potential issues of concern with respective agencies?

Ms Jones: They can certainly support agencies that require assistance, but we do not have a directive to actually direct agencies to look at or —

Mr D.T. PUNCH: It is not a matter of direction. I guess it is more of a leadership role. If, within the literature, you are seeing occupational groups recognised as having some difficulty, would you raise that with the appropriate director general and ask a question: "Is there a problem for your agency", or, "Are you aware of this research?"

Ms Jones: I think the research would be shared amongst the director general group, and certainly we are a lead agency in the mental health space so we would always work with those agencies to participate and give as much support as we could.

[10.20 am]

Mr Z.R.F. KIRKUP: I am just curious as to whether or not we have an assumption or a working expectation, I suppose, from within the commission about the number of people impacted by PTSD within the public sector? Do you have a dataset like that or any working assumptions about what that prevalence looks like? Because in this committee's case, we are certainly interested in things

like Department of Fire Emergency Services, ambulance, justice, police and the like. At the other end, as you rightly pointed out, there are the social workers in Child Protection or whatever that agency is now, right through to perhaps judicial officers.

Mr D.T. PUNCH: Emergency department workers.

Mr Z.R.F. KIRKUP: Emergency department workers, psychiatrists—does the government of Western Australia in any way, shape or form, either historically or presently, through the commission or any other means, have any belief or understanding how much of its workforce is impacted by PTSD?

Ms Jones: Certainly the role of the Public Sector Commission would have a significant role in terms of the public service. We have started to have initial conversations with the new WorkSafe commissioner who is expressing an interest of working with the commission in terms of the public service in general, not just first responders.

Mr Z.R.F. KIRKUP: As part of the agency that of course the commission is, in terms of being a leadership agency and implementing things like the plan and other programs, would it be useful—I am curious as to how we might survey or assess certainly those members of the public service who might be impacted by things like PTSD. Do you think that would be a valuable tool to help enable the commission to be able to deliver certain tailored programs? If we understand the severity or how much of the workforce is being impacted by something like PTSD, do you think that will be of value to the Mental Health Commission at all?

Ms Jones: It is something that the commission could work with the Public Sector Commission on. With surveys, often people—it depends on their willingness to disclose as well and people often will have a sort of natural suspicion about what happens to their information if they do disclose in a survey and how de-identified it is, or not.

Mr Z.R.F. KIRKUP: I appreciate that. I will give you the context of my personal consideration, I suppose, in this respect: obviously, all of us in this room think it is important to support the public sector and officers who have to confront whatever, emergency department, riots through the prisons or whatever it might be, the extremity of the bandwidth of the public service, or all instances within the bandwidth of the public service. We know it is a prevalent issue, we know there are subtleties although it is hit and miss, I suppose, on the prevalence and the population in emergency services personnel, and then defence personnel is relatively well researched in that respect I appreciate this is not the Mental Health Commission's primary responsibility. If we do not have an assessment about the prevalence of PTSD within the public service, how can we respond to that? It seems like we all know it is an issue; that is an accepted assumption, we all know it has a higher prevalence for emergency services, that is an accepted assumption, but none of us actually know the full rate of impact, I suppose, across Western Australia.

Is there any way, aside from a de-identified survey, that we might be able to assess that impact, aside from studies that we can then extrapolate and say, "Well, four per cent of people might have it, 10 per cent of emergency services might have it, we have 5 500 police officers, thus, 550 minimum have PTSD." Is there any way or mechanism that you think that might be available to the government here or anywhere else in Australia, or anything you can point the committee to, to see what we might be able to do to try and best assess the prevalence, I suppose, of this in our workforce?

Ms Jones: The latest report that was put out by Beyond Blue very late last year, early this year it was announced, and this is the "Answering the Call: national survey: Beyond Blue's National Mental Health and Wellbeing Study of Police and Emergency Services—Final Report" That went out

nationally to 21 000 emergency workers and people clearly felt comfortable in responding through the way that Beyond Blue did that survey. Have you been —

Mr Z.R.F. KIRKUP: I think we have copies there.

Ms Jones: Yes. Thank you. Again, I think some of the things that are brought to the fore is a supportive work culture, and I will just quote one thing out of there. It says —

First, a supportive work culture is like giving everyone in the organisation a mental health inoculation.

I mentioned culture earlier, so the ability to do surveys is there across the public service. This has been done by Beyond Blue for emergency service workers. We have done the survey and the work with the FIFO workers, so there is no reason why it cannot happen. There are also public service workers who do not work in the frontline and would not be considered first responders, but for example, in terms of vicarious trauma in the subject that they are working with. I can give you an example in the Mental Health Commission, the team that actually had developed and are delivering the suicide prevention strategy, very frequently, often on a daily basis, they will have communications from the general public, from families who have lost close family members, and people in the community who have real issues around farming trauma, all sorts of things that are going on at the moment. So you would not consider them to be frontline public servants, but certainly their day-to-day dealings with the matter that they are dealing with would possibly subject them to some trauma.

So, when I talk about organisation and culture, that is why it is really important to have the positive culture where people feel like they are in a safe, supportive environment where they can speak up and say, "I'm not travelling very well. This is really affecting me", and have a manager who is trained to know how to deal with that and how to help the employee. Often, if a manager is not well trained in this space—they just do not know what to do often—it can actually make issues worse. I think the matter of training is something for the public service in terms of mentally healthy workplaces and that is something that the commission is a lead agency on. Again, moving organisations towards the wellness model instead of "Tick the box, occ health and safety compliance", and that is what we are trying to do as a lead agency.

Ms Stone: A couple of things also to consider are that people may have symptoms of PTSD, but not meet the diagnostic criteria, or not have been diagnosed but still affected by PTSD. That can be a significant impact on people.

Mr M.J. FOLKARD: That is because industry does not have a standard diagnostic tool in that space.

Ms Stone: Yes. People diagnose it differently and it depends who you see and —

Mr M.J. FOLKARD: So how can you compare if you are not using the same diagnostic tool for PTSD across the community?

Ms Stone: Yes—or they may not meet the full criteria, in which case they are not sort of included in the scope of this conversation, but I think it is really important that they are considered. There is some research that suggests that emergency service personnel can experience depression as a consequence of work-related trauma, rather than PTSD, and then there are others who experience PTSD and then there are others who experience PTSD and depression. Vicarious trauma now fits the trauma exposure criteria of PTSD under the DSM-5, so that constant exposure to other people's experiences of trauma is well recognised in some areas like the sexual violence field, but not as well recognised in other areas.

Mr M.J. FOLKARD: I will put it to you that Department of Emergency Service workers are the ones who absolutely experience it, simply because of the complexity of their illness.

Ms Stone: Absolutely.

Mr M.J. FOLKARD: They take it home—simple as that.

Ms Stone: Yes.

Mr M.J. FOLKARD: That is why significant numbers of emergency service workers have such a poor marriage success, simply because of that.

Ms Stone: It has a significant social and relationship impact, does it not?

Ms Jones: Also, costs in the workplace in terms of absenteeism —

Ms Stone: Absenteeism, productivity —

Ms Jones: — effects on colleagues who have to support colleagues who are not travelling very well, not particularly knowing how to do it well if they have not had training in that space.

Mr D.T. PUNCH: Has there been any economic analysis of the impact across the public sector, or at the national level of PTSD?

Ms Jones: Not that I am aware of.

[10.30 am]

The CHAIRMAN: There was a recent senate committee inquiry that came out into the high rates of mental health conditions experienced by first responders, emergency service workers and volunteers. Has the Mental Health Commission considered the findings and recommendations of that report; and, if so, what areas do you think are particularly applicable to you and to the WA public sector?

Ms Jones: I would certainly have seen and looked at this report. Is this the one that is titled "The People Beyond 000: Mental Health of our First Responders"?

The CHAIRMAN: Yes.

Ms Jones: Yes. I think the key issues for the commission and for all agencies—the key themes that seem to be repeated—is that we really need more robust data collection and we need more research to inform the key issues in terms of what we do and does it work. We have EAP programs, we have lots of things happening, but I think these reports are actually saying, "Based on evidence, do we actually know if they are working?" I think that is a key outcome from one of the recommendations here. The other one is around better collaboration amongst agencies in terms of their employee support and employee wellness. I think that collaboration needs to stretch across the federal and state jurisdictions as well, so we are all trying to do the same thing in the same way for the same reason, which is to support first responders and all employees from trauma.

I think what has been pointed out is it is really important to have appropriate support services for organisations. People will report that if you are working in the police service, what you actually need in terms of training and support is different from if you are a first-line emergency nurse, for example, or a firey or whatever your type of work is—that the support needs to be actually tailored to you. I think that is particularly poignant with employee assistance. People generally access employee assistance when there has been an event, so something has happened and they go to employee assistance. Employee assistance can be well used, but also it needs to be relevant to the person and the incident that has occurred. I might not have a particularly good experience with my employee assistance—for example, I might not get on particularly well with a counsellor—and then that might

be a negative impact that I may not want to re-engage again with an employee assistance program. I think that is what we mean by appropriate support services and specialist services.

Another one of the recommendations talks to compulsory management training focusing on mental health. People become managers—they do not necessarily get that training and support to move from being perhaps a specialist technician to managing people, and managing people is important.

Mr M.J. FOLKARD: You seem to be focusing on managers, which is your frontline response, but that does not bring about cultural change. Why are we not having these conversations at CEO and directorship level and mandatory training at that level, so that it actually permeates back down through the agency?

Ms Stone: I guess these recommendations are from the Community Development and Justice Standing Committee, which is what we were talking about. You are quite correct: it does need to be through the whole organisation, from top to bottom, for it to be effective in terms of cultural change and supporting people who experience workplace trauma.

Mr M.J. FOLKARD: Is there any evidence that this is taking place through the public service?

Ms Stone: Not that I am aware of.

Mr M.J. FOLKARD: So, no.

The CHAIRMAN: You spoke about the collaboration. Are there equivalent bodies to your body in other states?

Ms Jones: Yes.

The CHAIRMAN: How do you work with them, and do you do any joint research with them?

Ms Jones: The commissioner is actually a representative on all of the other commissions across nationally. I understand that they work very collaboratively together as commissions and commissioners in terms of developing research and rolling out programs and how they are actually going to work together on a national framework as well as a state framework. I have not actually attended one of those, but that is my understanding. Just to answer your question in terms of that I was focusing on management training, I think the manager training is really important because they are actually managing the people. If they do not have those skills, they can actually do quite a lot of damage as well, if you work for a poor manager. We are also talking about compulsory first responder training as well for as many employees as you are able to do. Financially, some organisations I think perhaps struggle to pay for some of the training costs.

Mr M.J. FOLKARD: I think you are missing the point. What I am trying to say is that the people who actually develop the policies for those particular agencies are not receiving the training, so how are we going to change the culture that actually affects so the managers can actually deliver that thing? You said earlier on that the issue is cultural change within these agencies. That has been reflected in probably five of the reports that we have in front of us that have been done, but you have just told us that no-one is actually addressing the senior management of those agencies to actually train them. They certainly need training in that space, but it is not occurring. Do you see where I am coming from?

Ms Jones: Yes. Again, I do not go to the DG forums, so I do not know whether or not that is actually something that is on the agenda at the DG forum and in the remit of the Public Sector Commission space.

Mr D.T. PUNCH: There is a national group of the commissioners who meet and there are the DG forums who meet. Are there actually any published minutes or information that is shared back to

the agency about the content of those meetings, or any actionable items that are coming out of those meetings?

Ms Jones: Certainly the national commission meetings have minutes and are formalised, but I would need to check with the commission —

Mr D.T. PUNCH: Is it possible to have a copy so we could see —

Ms Jones: I do not see why not. I will check.

The CHAIRMAN: You could check. I mean, you may not own them. Probably one of the reasons why you may not be able to provide them is that you may not actually own them.

Ms Jones: Yes, but certainly we will go back and take that on notice.

The CHAIRMAN: Yes, if you could check, that would be great. Thank you.

Mr A. KRSTICEVIC: With PTSD and the different professions, has there been any work done in terms of the people who go into those jobs doing whether it be personality tests or some sort of analysis of individuals to say that these are the characteristics or the traits of these individuals that are going into these jobs, and they may or may not be the right characteristics or traits because they lead to PTSD in 99.9 per cent of the time, or whatever it might happen to be? You could then look at people more holistically and say, "Well, you're the right person", or, "You're the wrong person because you, according to statistics, will end up with PTSD and have all these issues". I know it cannot be that specific, but is there any work done from that point of view? Also, is there any analysis or work being done on the fact that we know that you are going into that situation, we know this is what you are going to end up with—80 per cent of you will end up with PTSD—however, if we do some training up-front, I will not say no people, but if we give them the skills and abilities and ease them through that situation and scenarios so that it builds some resilience, when they do then confront that, they actually are already familiar with it in a safe environment, and then in a non-safe environment, they are able to look at it a little bit more, I suppose—well, much differently?

Ms Stone: An article that I looked at, which is the "Work-related post-traumatic stress disorder" from *Occupational Medicine 2013*, issue 63, said that there are three main preventative strategies to prevent psychological distress following a traumatic event developing into a mental illness and one of those strategies was pre-employment selection, another one was training in stress management and the third one was early intervention. They argue, the authors of this paper, that self-selection in employment selection might actually already exist in place to sort of weed out some people who may not be suitable to particular work environments. In certainly places like the Army, there is a lot of psychological screening to try and make sure that everybody who is coming in is fit and healthy to be there, but optimal selection for mental fitness is difficult given that the most vulnerable often have been excluded initially, by themselves or by not getting offered an interview, and there is limited research into pre-employment selection on levels of injury and distress. So it is a preventative measure, but there is not a lot of evidence saying how we should do it or how well it works.

[10.40 am]

In terms of stress inoculation or training people to be aware and exposed to some of the trauma that they may experience, there is some evidence in this article again that says firefighters who have been trained seem to cope better compared with non-professional firefighters. Training in stress management is important for personnel at high risk of encountering traumatic stress. Workers become familiar with and learn to manage their own stress reactions. Stress management programs and experience in dealing with stress, physical fitness may actually preserve the wellbeing of highly stressed staff. They are suggesting here that a range of strategies, including that stress management

training, understanding the sorts of things they are likely to be exposed to in their workplace, as well as physical health and experience in dealing with stressful situations is probably going to be helpful in terms of preventing psychological stress following trauma at workplace.

Mr A. KRSTICEVIC: Is anybody doing that stuff? When was that paper written?

Ms Stone: In 2013.

Mr A. KRSTICEVIC: Have we progressed from there? Is it just a paper and just a theory and no one is actually doing an analysis?

Ms Stone: It is actually a meta-analysis of existing studies. They are saying there is some evidence that that could be helpful.

The CHAIRMAN: What strikes me, particularly with first responders, is that they undertake significant training before they even start their job, be they police, paramedics, fireys or the like.

Ms Stone: Yes.

The CHAIRMAN: Do you have any evidence of whether their courses include a mental health component; and, if so, are you involved in it or do you have any optics on that sort of training?

Ms Stone: The Mental Health Commission does not deliver mental health training. We fund organisations to deliver that training. However, we do provide training to the police academy, to the justice academy and to ambulance when requested, around alcohol and other drug-related issues and have woven things like trauma-informed care and practice as much as possible into that over recent years.

The CHAIRMAN: But you do not have a specific remit on that trauma-informed space?

Ms Stone: No, we do not.

The CHAIRMAN: Perhaps that is something we can look at. Can I ask an overarching question; if this committee was to inquire into mental health and wellbeing across the WA public sector, is there any area that the commission would like to see explored or have a light shone upon it? Would you have any broader comments to make around that space?

Ms Jones: I think anything that could be done to better the workplace and people's experience in the workplace, for employees and employers in the public sector, would be welcomed. Yes.

Mr D.T. PUNCH: Is there anything more specific than general wellbeing? Are there any particular risk factors you see in the public sector?

Ms Jones: I think organisational cultures are really important to people wherever they are working, whether that is the public sector or non-public sector. If you feel supported in what you are doing, you actually feel quite safe at work as opposed to unsafe. If you feel that you are supported to do the best job that you can, that you are not bullied, harassed, intimidated in the workplace—all of those things can only be very positive.

Mr M.J. FOLKARD: The research you spoke of before, as I said, my meetings in December—there is a conversation that is going on out there at the moment and there is peer-led review research in relation to psychiatric re-inoculating our first responders. That clearly puts the comments, the paper you referred to, out of date. What are your thoughts on that?

Ms Stone: Workplace PTSD is not my area of speciality so I cannot be across all of the literature. I have a good understanding of post-traumatic stress disorder. It is a particular area of interest for me, but workplace PTSD is not something that I am totally across the research for.

The CHAIRMAN: Thank you. That has been quite enlightening, so thank you for coming in today. You will receive a transcript of this hearing for correction of any transcribing errors; just make them on the transcript. If you do not return the transcript within 10 days, we will just deem that you think it is correct. We will also write to you about some of the information we spoke about, and perhaps can we also include that 2013 paper that you were referring to, Ms Stone?

Ms Stone: Certainly.

The CHAIRMAN: We will write to you about that, and request that information. Through the corrections process, you cannot introduce new material and you cannot change the sense of your evidence, but if there is anything you want to give us that you think might help us, we are willing to receive it, so just send it in as a supplementary submission.

Ms Jones: Do you have the FIFO research work that has been done by UWA?

The CHAIRMAN: We have not seen that. I certainly have not seen it.

Ms Jones: We will get you that.

The CHAIRMAN: If you could, I would appreciate that. Again, thanks for your evidence today and thank you for taking the time to talk to us. I will conclude the hearing.

Hearing concluded at 10.46 pm

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