COMMUNITY DEVELOPMENT AND JUSTICE STANDING COMMITTEE

INQUIRY INTO THE METHODS EMPLOYED BY WA POLICE TO EVALUATE PERFORMANCE

TRANSCRIPT OF EVIDENCE
TAKEN AT PERTH
WEDNESDAY, 18 NOVEMBER 2015

SESSION ONE

Members

Ms M.M. Quirk (Chair)
Dr A.D. Buti (Deputy Chair)
Mr C.D. Hatton
Ms L. Mettam
Mr M.P. Murray

Hearing commenced at 10.12 am

Dr MATHEW SAMUEL
Clinical Lead, PTSD Program, The Hollywood Clinic, examined:

Mr DOUGLAS BREWER
Coordinator (Clinical) of Trauma Recovery, Growth Programs, The Hollywood Clinic, examined:

The CHAIR: On behalf of the Community Development and Justice Committee, I would like to thank you for your interest and your appearance before us today. The purpose of this hearing is to assist the committee in gathering evidence for its inquiry into the methods employed by WA Police to evaluate its performance measures relating to the management of personnel. I would like to begin by introducing myself. I am Margaret Quirk, member for Girrawheen, the Chair. On my right—he will be back in a minute—is Dr Tony Buti, the Deputy Chair and member for Armadale. On my left here is Mr Mick Murray, member for Collie–Preston, and on his left is Mr Chris Hatton, the member for Balcatta. The committee is a committee of the Legislative Assembly of Parliament. The hearing is a formal procedure of the Parliament and therefore commands the same respect given to the proceedings in the house itself. Even though the committee is not asking witnesses to provide evidence on oath or affirmation, it is important that you understand any deliberate misleading of the committee may be regarded as a contempt. This is a public hearing and Hansard will be making a transcript of the proceedings for the public record. If you refer to any document during your evidence, it would assist Hansard if you could provide the full title for the record.

Before we proceed to questions I need to ask you a series of questions, and can you respond verbally rather than just nod your head for the purposes of Hansard. Have you completed the "Details of Witness" form?

Dr Samuel: Yes, I have.

Mr Brewer: Yes.

The CHAIR: Do you understand the notes at the bottom of the form about giving evidence to a parliamentary committee?

The Witnesses: Yes.

The CHAIR: Did you receive and read the information for witness briefing sheet provided with the "Details of Witness" form today?

The Witnesses: Yes.

The CHAIR: Do you have any questions in relation to being a witness at today's hearing?

The Witnesses: No.

The CHAIR: Just for the purposes of our inquiry, if you could briefly outline the history of post-traumatic stress disorder and in particular your experiences in treating police officers or former officers with PTSD.

Dr Samuel: Thank you for that question. PTSD as a diagnosis has been around for more than 40 years. It got that name of PTSD after the Vietnam War when the Vietnam veterans went back. It was largely known as shell shock in the First and Second World Wars. It was well known that people who experienced combat trauma were very different when they came back compared to

before when they went into the war. It had different names—war neurosis and shell shock—and then there was a big incident in Stockholm and that was known as the Stockholm syndrome, but then it got the name of post-traumatic stress disorder in the late 70s, and that is when people started looking at what happens when people are experiencing traumatic events in their life, whether it is army or civilian, or whether it is combat or non-combat, sexual assault and different entities. It came into the front line of science with the introduction of diagnostic systems manuals, or the DSM criteria. We are now into our DSM–5 criteria, which came into force in 2013. DSM is actually a formal diagnostic classification used by the American Psychiatric Association, but it has been widely used as research diagnosis and for funding reasons. I can go through the main criteria. The criteria says that the person has to be exposed to a traumatic event; it can be experienced, witnessed or confronted at an event or events. Following that, the person experiences or re-experiences the traumatic events in their daily life. It involves recurrent images, it involves thoughts and perceptions and recurrent dreams, especially at night. They feel that they are actually going back into that event every day and they have intense psychological distress; they have physiological reactivity. For example, they would feel their heart beating very fast, perspiring and feeling faint and nausea and things like that. Then they try to avoid those kinds of images or events surrounding the trauma, so they will try to avoid the thoughts, they avoid places, they avoid activities, and they will sometimes inevitably recall the traumatic event itself due to the traumatic memory. They will have decreased interest in activities. They will feel quite detached and then they will have problems in their effect and mood and they will feel that their life is going to be cut short. Then they will have persistent symptoms of increased arousal. For example, they will find it difficult to sleep at night. They have outbursts of anger, and that has been a huge issue. And they will be hyper-vigilant. They will feel that something is going to happen with them all the time. They will be walking on eggshells and have difficulty in concentration and startling forms. When a car backfires, they feel that they are actually back in Afghanistan or Iraq if they are combat victims. If they are fire, police or emergency personnel, anything to do with sound, smell or a thought sensation can take them back to that moment. Then the criteria says that they have to have social and occupational dysfunctioning. Just because people have got these thoughts it does not mean that they have got PTSD. They need to have significant social, occupational dysfunctioning. That is the criteria of PTSD.

[10.20 am]

The CHAIR: So with that last one, what sort of things would manifest social dysfunction?

Dr Samuel: They will have issues at work and in their personal attributes. They will have issues in their job and in relationships, and they will get into problems with the law. They will get into problems of drinking too much alcohol. So 82–85 per cent of people who have been diagnosed with PTSD will have what we call comorbidity in which there will be a dual diagnosis. Two major dual diagnoses can happen with PTSD. One is major depression and the other is alcohol dependence. We are actually dealing with almost three diagnoses at one stage. Hollywood Clinic has been involved. I will let Doug explain a little bit more about our involvement with PTSD.

Mr Brewer: If I could just add a little bit to the concept of PTSD, while it is a normal response to recover from a traumatic event—indeed, we are born capable of doing that—unless we are very unlucky, we are going to have to deal the death of someone close, which can be in itself traumatic. It does not meet the requirements of PTSD, but it is a traumatic event. The difference between PTSD and someone who recovers from a traumatic event is that the sense that this event has not been date-stamped. There is not a sense in which I get a feeling that this occurred some time ago, as I would with normal grief. It is many years since my mother and my father passed away and I can be very moved at times, but that it is not as though it is happening in the here and now. With PTSD that is what occurs. It is re-experiencing it in such a manner as though I am reliving the event. The normal response to that for human beings is to try and avoid the situation. That is a big issue with PTSD. We avoid people, places and reminders of the event. We avoid socially mixing with

people that might bring those to the foreground, because the fear is that if I am triggered, I will emotionally be unable to contain this arousal and I will look a fool in public. We then see all these other issues and a lot of the other secondary comorbidity issues that Mat was talking about occurring.

In terms of our involvement at Hollywood Clinic, in Australia the research was largely picked up following the formal diagnosis by Melbourne University. They got a grant from DVA because of their concerns with the presenting number of soldiers following Vietnam. That research was complete. The grant was to see what was the gold standard of the evidence-based treatment that was, of course, being done worldwide, particularly in America. By the mid-1900s it was quite clear what the best form of treatment was—where the evidence base was. DVA then asked for 12 centres to be set up Australia-wide, with one in all the major cities. Here in Western Australia Hollywood Clinic was it. We were trained and put into place a very formal, evidence-based, scripted program for treatment for veterans. Because of the high number of veterans who had been conscripted and were now moving back into other occupations, as we dealt in 1995 onwards with veterans, we were also picking up a large number of people who were now in uniform services, such as the police, the fire brigade and paramedics elsewhere. Our expertise, while we were trained and were becoming very skilled at evidence-based treatment, was starting to widen to realise that police actually were not getting access to this. In 2006, we commenced a program specifically aimed at younger veterans because evidence was showing us we were not getting the treatment outcomes that we were with Vietnam veterans. We needed to be more specific and move with the times. We commenced a treatment and were encouraged by the Australian Centre for Posttraumatic Mental Health, which is attached to Melbourne University, to do the research on what would be the best outcome. The research that we did at Hollywood Clinic in developing that program then became the benchmark for Australia and was designed to cater for uniform personnel as well. That was a lengthy program. Our difficulty with that program was that getting people who were still employed into a lengthy program would not be possible, and so the next progression as we moved on, which was around 2010–11, was that we started to tailor a short, intensive program that was not going to give us the same outcomes that a lengthy 10-week intensive program would give but would allow the basis of the expertise that we would develop and get the evidence-based skills that were needed for recovery in a three-week component. That is what we run currently—a three-week program, as well as the longer program, for emergency services workers. That will require ongoing work. After that we are going to do the exposure work, which again is necessarily evidenced-based. That is best done one-on-one following that. So at the end of that three-week program, we are able to give a treatment package back to whoever it is who is going to follow and we will liaise with them about what we have learnt in the three weeks, what we have uncovered, what skills this person has and what additional treatment is needed as they get back to employment again.

The CHAIR: I have a couple of general questions about PTSD. There is, I think, the traditional view that it is mainly exposure to one large traumatic event, but it can also be an accumulative thing over many years.

Mr Brewer: That has changed very clearly with the DSM–5, which came out in mid-2013. That clearly identified that we were starting to see that we could not deny the evidence that many people presenting cannot identify one particular event and we know that there is an accumulative effect. So now the diagnostic criteria allows for that because it is clearly not true anymore. We have learnt. One of the big mistakes that were made was that the early diagnostic criteria for DSM–III, as it was in those days in 1982, was largely built on the Vietnam response. Of course, PTSD has been around—Shakespeare wrote about it and the early writers wrote about it. I think the latest thinking is that had we developed the criteria based on sexual abuse, for instance, which was widespread, we would have a very different criteria than we do today. So it has taken some years for us to recognise that this is not just a post-Vietnam problem and not just military and that it needs to be widened.

We clearly have today a very clear understanding, evidence-based, that it is not about one event; it may be about many events.

The CHAIR: I have just one other question before my colleagues ask questions. There seems to be a bitter split between two schools of thought. There is one that says that straight after the critical incident you should do a debrief. Others seem to think that that is not a good idea and that you could compound the issue and you are better off waiting until patients present themselves at some of these centres before you do something.

Mr Brewer: For many years the jury was out, so to speak. We were not sure. There was evidence that it was doing damage and there was evidence that it seemed to be doing some good. That is being cleared now. There is no reason for ignorance. The evidence is very clear about the way critical-incident debriefing needs to be attended. Essentially, it is not to bring in the professionals, as we would do in the past when the police helicopter had an emergency landing at a primary school. Immediately the education department would bring out half a dozen psychologists to work with the children. We now know that the evidence is that that is damaging. It says very clearly, "This is a terrible event and you need help right up-front." What we need now is the people who are there on the ground capable of giving the basic comforts of, "Here's a cup of tea. Let's go back and talk about that", and then follow up later behind that, not in the first instance. It is very clear. Evidence is there for us now as to what that critical debriefing should entail and what it should not entail, so it has changed.

The CHAIR: So in terms of—sorry, doctor.

[10.30 am]

Dr Samuel: The International Society for Traumatic Stress Studies has come out with a guideline. Guideline 3 states very clearly that early cognitive behavioural intervention when people are exposed to trauma is highly desirable. It says very clearly that the strategies suggest psycho-education, which means giving more information about what happened.

The CHAIR: About knowing the signs.

Dr Samuel: Yes. Stress management, skills training, cognitive therapy and exposure therapy are the four things they say will prevent a chronic PTSD at a later point of time.

The CHAIR: All right. So, if you like, the stereotypical behaviour within, say, police is for the boys—in those days it probably was boys—to go out and have a beer, get it off their chest and come back and man-up and just get on with the job. That does not bear the good hallmarks of —

Dr Samuel: No. I think we found the same thing with the fire service as well. That is what they do. After a major incident they all get together and have a cup of coffee or go for a beer, and then say, "Look, you've done a good job", and that is it and nothing happens afterwards. Maybe a visit from the chaplain will happen. It also about the threat of their future jobs. It is a stigma. Let us face it, mental health, even though we have come this far, has got a huge stigma. Is it actually a manly thing to say, "Look, I have got PTSD and I have got stress and anxiety"? What they will do is that they will go and get refuge from alcohol, and then they will have huge issues at home, and it will become like a cumulative effect one after the other unless we address it at an early stage.

The CHAIR: Doctor, you mentioned firefighters. The police that you have seen at the clinic, do they exhibit any sort of traits and are they exposed to any treatment that is a bit unique to the police and that you have not seen in other kinds of patients?

Dr Samuel: I think the issue there is that as a police person they are supposed to—the PTSD, as we said earlier on, is about typical incidents around what happens. They are still supposed to get back in their car, they have to do high-speed chases, they have to carry a firearm and they have to get confronted with similar episodes in their everyday life. How they could actually cope with their job—and each of the uniformed officers face the same issues; for example, for the fire service

person, the siren going on, the colour red, the fire, the smell and all those things have got triggers around the PTSD. It is the same issues with the ambulance personnel: blood, smell and all those things will reignite the PTSD. I think each uniform have got specific triggers which they need to handle. For the police, the main triggers are getting back to operational duties and getting back into front-line real policing, which will become a real issue in terms of their therapy. What do you think, Doug?

Mr Brewer: I think one of the things that stands out in treating the police is the reluctance to get treatment early. All the evidence is that the earlier the treatment, the better the outcome. Of course, the very nature of the job is that sometimes it will take a long time before an event that is going to occur will bring that to the foreground—that they are not managing. But then what happens is that gets missed and not diagnosed or not understood, and it goes underground or they try to cope and then they will develop the secondary issues—alcohol, relationship problems, not functioning at work—and then the treatment window is missed. I think that is a key problem.

The CHAIR: Is it common for patients to report that their manager or their supervisor did not appreciate the issues and compounded the problem?

Mr Brewer: Yes. There has been a slight change. But one of the major issues, I think, from what I pick up working with them, is this sense in which the person believes, "Either I am fit for work or I am not fit for work, and if I'm not fit for work, then I should stay away until I get better." But the guidelines for the treatment show us that we need a graduated exposure back into the workplace. We are not going to get fit for work by staying away. I think the cultural change needs to become seeing PTSD as any other form of illness. We treat mental illness as though if you stay away, you will be better tomorrow and you will come back—a bit like having appendicitis and you have recovered and now you can come back to work. That is not the case. We are going to need to come back, particularly with trauma, with a graduated exposure. The person needs somewhere they can build up their hours so that they come back fit for work, but they also need to build up their exposure to those triggers that will be there and are a hallmark of PTSD.

Mr C.D. HATTON: Do you think, from your knowledge, that in its simplest form WA Police actually has structures in place to deal with it before it gets to you?

Mr Brewer: Unfortunately, while they have very good health and welfare services and the avenues are there and they are particularly serviced, I think, in that essentially it does not matter where you get the treatment so long as you are getting treatment. So they will support the treatment funding for that, which is commendable. The difficulty is that many police, as in many other forms of work, will not go to work-related support because it will be documented, and the fear is that this will affect their progression through the police force. So whilst there is a good service there, many will bypass that. Then, I think secondary, both with the police health and welfare and with treatments through GPs and then directed out to other people, the difficulty is educating people to do a thorough assessment so that we can identify what the issue is. Over the years, we see that often with PTSD and other forms we pick up on the problems that are easily displayed, such as marital problems and we see relationship problems and we pick up on the problem that this person is drinking too much but we do not go behind that to see what are the core issues here. So that is where the problems are.

Mr C.D. HATTON: Thanks; that is a good answer. There is a structure in place for the welfare of the officers, but what about the culture?

Mr Brewer: Those are two different things.

Dr Samuel: I think that is also two different things. I think they also have a police psychiatrist. They are employed by the WA Police to look at the welfare of police. If they report that they have problems, they have psychologists and psychiatrists. But the issue is the trust of the people in that system. We recently had a police officer who said, "Look, I don't want certain information to go

into my file, because I'm actually coming to Hollywood and it is paid by the WA Police", and obviously if WA Police is going to ask for the files from us to them, he does not want that information to go into his file. So there is a lack of trust within the force about the level of treatment and the level of support they will get. Like I said in the beginning, one of the major symptoms is that people who are suffering from PTSD feel that their life is cut short. Plus, they are facing disciplinary action or a downgrade from their job to nonoperational or they have issues in their promotion. They will feel that, "Oh, well, I don't want to actually say anything about it." We recently had another gentleman, who is a super in the police, who came and said, "I don't want the police to know that I am actually coming and getting help here." And they are coming out of the police force to get help. So, yes, there are systems in place, but I think that probably we also need to let people know that we are here to help them outside the police force as well.

Dr A.D. BUTI: I have a couple of questions about the issue about trust and, of course, confidentiality. I can see a police officer being really concerned about seeing a psychiatrist within the force. Do the police have their own psychiatrist?

Dr Samuel: Yes.

Dr A.D. BUTI: Okay. I can see that being a real problem. But if they come to you, surely there is no obligation for you to relay that information back to the police force, because you are the owner of the notes and no-one else is the owner of the notes.

[10.40 am]

Dr Samuel: Unless there is a compromise for the society, unless there is a risk posed, because if that person is carrying a gun and I am actually concerned that there is a significant threat to that person or to other people, to the public, because I think that as a psychiatrist I have a duty towards society.

Dr A.D. BUTI: I understand that. Of course if there is a problem with the police officer and you think they might injure themselves —

Dr Samuel: I have no obligation to relay that information to anyone else unless it is subpoenaed by the court or there is a risk involved.

Dr A.D. BUTI: Yes, that is right. We have heard the information that the WA Police has refused to pay some of the courses that police officers have come to. Is that true?

Dr Samuel: We had issues, probably many years ago, but I think one of the things the both of us have done over the last 12 months is to bring things together. We tried to go and see the commissioner many years ago and the doors were shut, by saying that there is no such thing as PTSD in the force. But we have not actually lost it all because we have been seeing people, in spite of that, on a regular basis. So people have been hearing and colleagues had been coming and telling people about the program we do. We have slowly worked with the health and welfare, and in fact we had an evening with the medically retired police association, health and welfare and the Police Academy. We actually brought people into Hollywood by saying, "Look, this is our service." One of the problems with Hollywood, I should tell you at the outset, is that we are a private hospital; we are not funded by the government and both of us are private practitioners, so when we try to approach people, there is always the issue of money and finance. We have to say, "Look, we are not a government agency. We don't get paid by the government. Obviously money is important." There is a little bit of an issue there when we approach these agencies. But in spite of that, health and welfare over the last 12 months have come to the party. Whenever we have put in a request for police officers to get help, they have actually come and paid for it. There is a little bit of delay but we delivered it and at least we actually want to get our people help.

Mr Brewer: The change has occurred. We have seen that very clearly. But there have been instances, as you said, where there has been—and the most damaging I think would be at the end of the career where it was quite clear that this person was not going to be able to return to duty—the

statement that was given was that doing a program would not help at this stage. I think that is one of those cultural changes that need to occur. In this case they waited. Once they exit the police force medically discharged, they do come under the RiskCover, which is for retired policemen and they are able to get treatment like that. But that is very damaging when we start to shift the availability of treatment for the individual. The longer treatment goes the more damaging it is. So, yes, there have been instances but they are fairly rare now.

Dr Samuel: One of the things is that when we approached the police many years ago, the fear was that there would be a floodgate of people coming up and saying that they have got PTSD and want compensation. But if you look at the research, that is not the case. It is actually a very baseless fear that people have. It is about education. I keep telling people that I think we should be given an opportunity to go and tell the police force by saying, "Look, help is available, if you want." Our job is not to get rid of people from their job but to get back people into their job in a more quality way.

The CHAIR: My feelings from outside is that the health and welfare people have kind of got the message but it is the direct line-supervisors that have not been trained in psychological first aid and are likely to say something stupid like, "Dry your eyes, princess, and get on with it." That is the problem.

Dr Samuel: If there is a culture change, that will also help the return-to-work program in a greater fashion and the return exposure treatment we were talking about to make sure that these people can actually get back into operational duties or non-operational for a period of time. If there is support from the superiors, this approach will become very easy.

Mr M.P. MURRAY: I have a comment. I was thinking that the old adage "get back on the horse immediately" is at the forefront.

The CHAIR: RiskCover I think has said that payouts are always predicated on being able to identify a specific incident. Do you think they are being flexible enough in terms of PTSD-type diagnoses?

Mr Brewer: Yes, I have no complaints with RiskCover. I think they have now been very quick to respond, and once a formal diagnosis is done there does not seem to be a problem with that.

Mr C.D. HATTON: Frontline policing can be very dangerous and can be very traumatic, whether it be road trauma, domestic or other. Do you think there should be in the police training, actual units in place for traumatic stress disorder and training by guys like you, showing what it feels like, looks like and sounds like, so that people are ready and a little more prepared for it, and you can have self-identification as well as other identification?

Mr Brewer: Absolutely, and again this is something where we can turn to evidence and say that the evidence is strong and that that is a positive investment. In Victoria, Queensland and New South Wales, they have done a considerable amount of research on helping people build up resilience, and that is done in the initial training. Programs have been put in place and checked following entry into the force and then some years on. We know that that needs to occur. It certainly needs to continue and be clearer about when and what it is or what it is people need to be aware of, so your comment about being able to self-diagnose is not, "What do I have", but, "I need help and this is the avenue I need to go". That is not clear still.

Mr C.D. HATTON: What importance do you place on that with police?

Dr Samuel: Huge importance, absolutely. We have tried to say that to the ambulance, police, fire force and the military. We keep telling them. I think the other important document, which I would like to refer to, is the expert guideline, and this is the world-first guideline produced by Australia in terms of looking at the treatment options. Because, so far, whenever we go across to uniformed officers or uniformed places, the question is: what kind of evidence do you have? Now we have evidence, which was released only a couple of weeks ago. It just follows what we have been telling people. The other thing we do in Hollywood is that most of the other programs are psychologically

led; there is no medical oversight. The unique program about Hollywood is that it is both psychologically and psychiatrically led, so it is a combination of medications, individual therapy and group therapy, which is what the evidence says. And we follow the return-to-work program, rehabilitation and getting back on the horse, not immediately but after doing the treatment.

The CHAIR: Do you think there can be some merit in getting some of the senior management of WA Police along for maybe an extensive briefing at your clinic as to what is involved? It seems to me that there is some resistance about sending officers there to the clinic, that they do not believe it will be of some utility and with a lot of the officers that they will be finding themselves in the courts.

Mr Brewer: That would be extremely beneficial. I think this goes to the heart of the matter. There needs to be a cultural change, and that starts right from the top down. Of course, that is not unique to the police force. We see that in any other service like this. The Australian Defence Force has tried to work at this process and in fact has started to make officers in charge responsible and answerable for why it has got to this stage without treatment. I think it is the top down as well as treatment here early in the piece. The culture has to change.

[10.50 am]

Dr Samuel: I think we have been trying to get a memorandum of understanding. We have got a memorandum of understanding with the Australian Defence Force, so whether it is the Air Force, the Navy or the military, we can admit them at any time. We can get them into programs and we can look after their mental and physical health at Hollywood. We were hoping that the uniformed officers—we tried with St John's, we are trying with the FIFOs and we have been trying with the police, by saying that if there is a memorandum of understanding—as a private hospital, the problem we have is that if we do not have a steady number of patients, we cannot employ people, because it is a private thing. That is one of the Achilles heels that we have been having issues with. If there is a memorandum of understanding between Hollywood Private Hospital and WA Police, we can say that we are happy to look after their members' health needs, so that people will feel confident and they will feel they can trust us by coming and seeking help. That will also involve, as you said, getting people across to Hollywood for a briefing. We will support them and help to look after their colleagues and their peers.

The CHAIR: In terms of psychological first aid, how long do you think it would be optimal if you needed to change a supervisor of staff or manager? How long would they need?

Mr Brewer: Sorry, I am not quite clear.

The CHAIR: Psychological first aid—how long? Say it is a supervisor of operational staff, how long would it take to get them up to speed with those notions, what they needed to look for and how they were to deal with a staff member that presented with some symptoms?

Mr Brewer: I do not know that we can train, because that has been tried elsewhere and not been terribly effective. We are not asking them to be able to diagnose —

The CHAIR: Not diagnosed but —

Mr Brewer: — to be able to see those early warning signs. I think any exposure is going to be beneficial. But in terms of how long, we have run days like this for GPs to help them identify with this cohort and with other areas what they should be looking for and when is the time to suggest that. We have done that from a three-hour period to a full Saturday, for instance, and found that to be extremely beneficial. They now understand the process, how we get people into the clinic or how we get them to assessment. So anywhere between three hours and a day.

Mr C.D. HATTON: Can you give me any insight into predisposition, I think you might call it, with resilience and the senior officers saying, "Get on with it lads. You're all right." Whereas they do not

understand it is like domestic violence, "How far do I go in dealing with someone's life?" Would that be a part of what you would teach?

Dr Samuel: Yes, absolutely. Again, one question the people always ask is that the statistics say there are only about one in 10 people who are attending these kinds of traumas and looking at PTSD, so why do the other nine people not get PTSD? It is always a question we are asked. Obviously there are a lot of factors. As you said, there are predisposing factors and there are a lot of perpetrating factors. I think understanding is required about the trauma and the effect that trauma has on that person and how people have survived their traumas in the past—what kind of psychological measures they used to actually cope with the things.

Mr C.D. HATTON: I am just putting it into a simple form. The education department employs 30 000 people. A school burnt down last week in my electorate—not burnt down but there was a fire with fire trucks at the scene. But I spoke to the principal a couple of days later, who said, "It will be all right, Chris, because we teach resilience at the school. The children know what it's about and we will just say this is one of the things that happen in life and we have got to get on with it." They have got these structures in place. If that culture was in the police force from top down, would it be good?

Dr Samuel: Absolutely, and I think that needs to start right from the time when they get into the academy, throughout their career, even as a young constable. It has to come and there has to be a culture shift. The old attitude of, "Toughen up princess. You just need to get on with your life. Don't come crying about any of these things", or, "Let's go and have a beer", after a critical incident is not the way to go. It is about involving them, asking them how they are, and there has to be a time frame. One month after the critical incident, one month after someone has been shot at, we need to ask them how things are. One thing I take from the officers is that they say they do not want to go and talk to a police psychologist or a police psychiatrist about this because if somebody comes to know that you are going and getting help and checked up, they will feel that you are not up to the job. That is why we are saying that probably an outside force like us or any other service can provide that kind of psychological debriefing or improve their resilience, which will help them in their job in the long term.

Dr A.D. BUTI: Can I just clarify, though, and I may have got a question wrong, I thought the question from Chris, the member for Balcatta, tended to suggest that the principal was saying that the kids have got resilience and will get over it. I thought you initially said absolutely, but it is not what you are actually saying, are you? You are not saying that the police are not resilient; you are saying that the culture in the police force is to get on with it, and that is a bit of a problem.

Dr Samuel: It is an issue.

Mr C.D. HATTON: I did want to clarify that I was not dismissing that people have real problems.

Dr Samuel: I believe in the police force in WA. They are an amazing group of people. If I state that they are not resilient, it is not a good thing to say. They have got resilience and they face a lot of issues in their day-to-day lives, but it is about how they can be supported in their workplace.

Dr A.D. BUTI: You mentioned a culture thing. You said that things have certainly improved and that there is recognition of post-traumatic stress disorder, but do you think it is still treated differently than something physical?

Dr Samuel: Absolutely.

Dr A.D. BUTI: And that is where the problem still remains?

Dr Samuel: The stigma of mental health is still a major cloud hanging over their head.

Dr A.D. BUTI: Was it not someone in your profession that is the problem for this? Was there someone who said, "What if you treated the mind like the body?" Really, it is one thing, is it not?

Dr Samuel: Absolutely.

Dr A.D. BUTI: There is a famous psychologist or famous psychiatrist who said it.

Dr Samuel: If you look at the stigma, who creates the stigma is actually the mental health people themselves who create the stigma. I think we are responsible for that. But absolutely they are treated very differently. If they have a fractured hand, they are treated very differently compared to having a PTSD.

The CHAIR: Doctor, what was the document you referred to? What was the name of it?

Dr Samuel: It was "Expert Guidelines: Diagnosis and Treatment of Post-Traumatic Stress Disorder in Emergency Services Workers". That is actually endorsed by my college, the Royal Australian and New Zealand College of Psychiatrists; the University of Adelaide; the Monash University; the Phoenix Centre, which is the Australian Centre for Posttraumatic Mental Health; Griffith University; St John of God; the University of Sydney; the Black Dog Institute; and the University of New South Wales. It is a well-researched, well-documented piece of work.

The CHAIR: Thank you. Thanks to both of you for your time and for your evidence before the committee today. A transcript of this hearing will be forwarded to you for correction of minor errors. Any such corrections must be made and the transcript returned within 10 days from the date of the letter attached to the transcript. If the transcript is not returned within this period, it will be deemed to be correct. New material cannot be added via these corrections and the sense of your evidence cannot be altered. Should you wish to provide additional information or elaborate, please include a supplementary submission for the committee's consideration when you return your corrected transcript of evidence. Thanks very much. That was really helpful.

The Witnesses: Thank you very much.

Hearing concluded at 10.58 am

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