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IN THE FIRING LINE

Emergency Services personnel exposure to occupational health stress and the role of PEER Support to combat the effects

For most Australians, it is extremely comforting to know that no matter what happens, our emergency services organisations are always going to be there to help. No matter if it's Police, Ambulance or Fire; we all rest well at night, safe in the knowledge that a phone call can summon support to attend to us in our direst need.

But, how many people actually think about the health and wellbeing consequences for the emergency services personnel, attending accident after accident, fire after fire, assault after assault and a myriad of other tragic and often highly traumatic events.

Over time, this exposes emergency services personnel to considerable and often long lasting and devastating occupational health stress, which, if left unchecked, risks the health and wellbeing of the very people that are there to protect us.

What we will cover in this article is the context and antecedents of occupational stress in an emergency services environment, the effects of stress in these high risk environments and the costs associated with occupational stress. Further, we will discuss what interventions should look like and focus specifically on PEER Support programs, and how they can prevent and assist in identifying and managing the overall recovery journey from mental health issues. Lastly, we will look at the recommendations made by the 2012 West Australian Government Inquiry and what 2CRisk is doing to support these recommendations, specifically with regard to mechanisms for analysis of attendance at incidents and the impact.

What is occupational stress?

Occupational Stress is considered to include work pressure, harassment at work, exposure to traumatic events, lack of autonomy and/or support and exposure to workplace and occupational violence. Forty three percent (43%) of all adults suffer adverse health effects from this type of stress (Miller and Smith, 1997).

Occupational stress occurs most often for work characterised by high job demands, low job control and low support. These specific job characteristics also match those of emergency service workers (police, ambulance and firefighters) and others occupations considered to be 'high risk'. In a summary of the voluminous occupational stress literature, Naude and Rothmann (2003) listed the effects to include impaired performance or reduction in productivity, diminishing levels of customer service, health problems, absenteeism, staff turnover, industrial accidents, alcohol and drug usage and purposely destructive behaviours.

The antecedents of occupational stress, as classified by Johnson et al (2005) cover eight broad categories:

a. Work relationships – interacting with people at work
b. The job itself – nature of work
c. Overload – load/time pressures
d. Control – lack of control over work processes
e. Job security – uncertainty re job future
f. Resources and communication – inadequate technological and other resources and ineffective communication processes in the workplace
g. Work life balance – conflict or interference between job and family/personal life.
h. Pay and benefits – perceived and/or actual inadequacy of remuneration and other important tangible benefits.

These antecedents are commonly accepted as 'part of the job' for all the 'high risk' occupations and combined with the continued exposure to trauma provide the ingredients for very poor health outcomes in this workforce, in particular long term stress can lead to post-traumatic stress disorder.

In a study of police officers in the US, Liberman et al (2002) concluded that '*Routine occupational stress appears to be a significant risk factor for psychological distress among police officers, and a surprisingly strong predictor of post-traumatic stress symptoms'*(p.421). Firefighting too, is considered one of the most life-threatening and emotionally traumatic occupations. Sweeny (2002) witnessed the physical, mental and emotional traumas experienced in the field as a firefighter, she was also a mortician, and has since set up programs to assist and develop coping mechanisms in firefighters (Sweeny Alliance, 2014). Her research found that the high levels of occupational stress that firefighters routinely encounter can lead to chemical dependency, physical illness, emotional problems, post-traumatic stress disorder (PTSD) and poor inter-family relationships including divorce. More importantly, the 'rate for diagnosable PTSD among firefighters was 16.5% compared to a 1-3% rate for the general population – about 1% higher than the PTSD rates of Vietnam Veterans' (De Angelis, 1995, p.36).

The effects of stress on high risk occupations:

High risk occupations do not produce positive health outcomes for their workers.

The effect of stress is reviewed specifically below for emergency workers, police, shift workers, firefighters, ambulance officers and soldiers returning from deployment.

Emergency work is often associated with negative health outcomes such as increased risk of injury, cardio vascular disease and other health problems, psychological health disorders and burnout (Kowalski and Vaught, 2001). When they are not able to cope with stressful events, they often experience undesirable psychological and somatic outcomes, which could lead to chronic stress, burnout and even quitting their profession (Anshel, 2000). More specifically, Donnelly (2009) found that emergency workers in the US, reported exposure to traumatic events to be between 80 and 100% and rates of PTSD to be greater than 20%. The same study found high risk alcohol and drug use reported to be as high as 40%. Donnelly's' proposed model (2009) suggest direct linkages between occupational stress exposure, chronic and critical incident stress, PTSD and high risk alcohol and drug use for emergency workers.

Costs

The costs of occupational stress are no doubt significant despite the scarcity of comparative and recent figures to illustrate.

A recent article by PWC entitled, "*Creating a Mentally Healthy Workplace, Return on Investment Analysis"* indicated that the impact of mental health conditions is measured as the total cost of absenteeism, presenteeism and compensation claims estimated in one year across all industries. This is estimated to be approximately $10.9 billion per year. This comprises $4.7 billion in absenteeism, $6.1 billion in presenteeism and $145.9 million in compensation claims.

The National Trauma Research Institute (2014) reports that traumatic injury costs the Australian health care system over $3.4 billion per year and the Australian economy $18 billion per year. Survivors often face lengthy rehabilitation and over 600,000 Australians are living with a disability caused by injury. The National Health Service in Northern Ireland reported that mental ill-health was the single largest cause of expenditure, causing 2 million lost working days each year (Department of Health and Social Services, 1993). Similarly, in the United States, it is estimated that the overall business and industry costs associated with burned-out and dis-spirited employees are in the range of $150 to $180 billion per annum (Wright and Smye, 1996).

Intervention

Whilst interventions to date for high risk occupations are minimal, the discussion surrounding what is effective and what works (or doesn't) is vast. For each type of intervention, there is evidence of criticism and in some cases – research to back the critique. For the purpose of this article, the most common stress management strategies consist of:

i. Critical Incident Stress Management (CISM),
ii. Critical Incident Stress Debriefing (CISD),
iii. Employee Assistance Programmes (EAPs),
iv. Proactive Stress and Resilience programmes, and
v. Peer Support Programs.

Peer Support

Whilst there is no one universally accepted definition of peer support, Sherry Mead offers the following:

"Peer support is a system of giving and receiving help founded on key principles of respect, shared responsibility, and mutual agreement of what is helpful. Peer support is not based on psychiatric models and diagnostic criteria. It is about understanding another's situation empathically through the shared experience of emotional and psychological pain. When people find affiliation with others they feel are 'like' them, they feel a connection. This connection, or affiliation, is a deep, holistic understanding based on mutual experience where people are able to 'be' with each other without the constraints of traditional (expert/patient) relationships." (Mead, 2001).

Over the last 10 years, the sharing of lived experience has been increasingly recognised as an integral, complementary part of the recovery journey in mental health. Formal recognition has led to increasing numbers of paid peer support roles and a diverse range of terminology, services, activities, practices, protocols, research and resources. These have been developed by individuals, community and special interest groups, health professionals, government departments and support agencies, all aiming to harness the power of peer support for consumers of mental health services and their families/carers. Peer support can be provided in a range of ways:

- One-on-one or in a group
- By volunteers or paid employees
- Peer-led or facilitated by a health professional (for example, a psychologist or psychotherapist)
- In person, on the phone or via the internet
- Through workshops or social activities
- In ad hoc or ongoing formats

Creamer et al (in submission) have identified that although peer support programs have emerged as standard practise in high risk organisations, there is little consensus in how peer support is defined, its goals, how programmes are implemented and their effectiveness across a range of outcomes. Creamer and his colleagues also propose that the identification of these parameters of consensus is an important step for assisting the field to move forward. As a result a set of guidelines has been developed by a group of international experts working in the field of peer support. The motivation for the research team at the Australian Centre for Post Traumatic Mental Health was to utilise these guidelines as a starting point for design and implementation of future peer support programs in high risk organisations.

Generally speaking, PEER Support networks appear to run very well when they are aimed at "situational stress". For example, an incident occurs, responding personnel are affected by the incident and PEER Support members are engaged immediately to assist those responding to the incidents.

This may include "download" sessions, group sessions or just someone to talk to and go through the incident with. PEER support can also be very useful in setting a triage environment

whereby external agencies, such as EAP Providers, General Practitioners, Chaplaincy, social workers and other mental health practitioners can be engaged.

How do you identify trends to improve support?

What has been identified in the literature is that by providing adequate (and appropriate) levels of support, including supervisory support, together with the use of adaptive coping behaviours can significantly reduce occupational stress (Brough and Biggs, 2010). This should also include resilience and stress management training so that emergency personnel are better equipped to be able to identify when they are "at risk" and indeed when their colleagues are at risk, so that a focus upon preventative, longer term initiatives can be implemented.

In order to do this, there is one glaring issue, which was identified during the 2012 West Australian Parliamentary Inquiry into the recognition and adequacy of the responses by State Government Agencies in experience of trauma by workers and volunteers arising from disasters

Finding 2 of the Inquiry indicated that *"All of the State's Emergency agencies have no mechanism for tracking their staff and the number of traumatic events they have attended over a particular period."*

The Inquiry went further in the recommendations, stating *"The Ministers for Emergency Services, Environment and Police ensure that their departments develop as a high priority a computer system for tracking their staff and the number of traumatic events they have attended over a particular period"*

A hyperlink to the WA Parliamentary Inquiry can be found below

http://www.parliament.wa.gov.au/Parliament/commit.nsf/(InqByName)/Inquiry+into+the+recognition+and+adequacy+of+the+responses+by+State+Government+agencies+to+experience+of+trauma+by+workers+and+volunteers+arising+from+disasters?opendocument

What is 2CRisk doing to address this issue?

2CRisk is a dedicated on-line, software platform assisting organisations identify and reduce Health Risk

Since July 2013, 2CRisk has been working with Ambulance Victoria to develop and implement a dedicated and purpose built Event Management application for tracking of critical and non-critical events and linking individual emergency service personnel to these events. Through the daily analysis of the events using key case characteristics by PEER Coordinators, teams and individual paramedics are identified for follow-up.

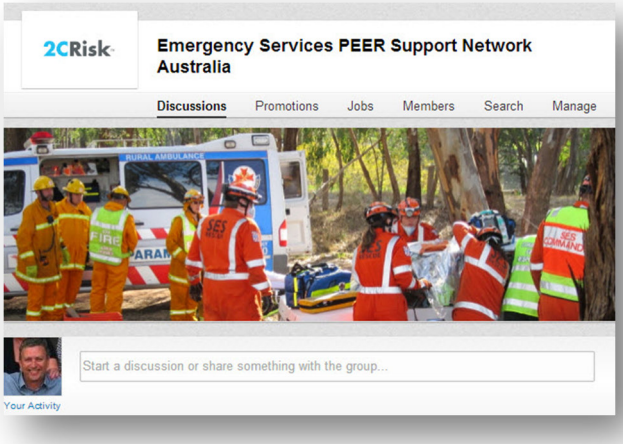
If the individual seeks ongoing support, the case management activity by the PEER Support Team and a network of Psychologists is captured.

This approach enables proactive intervention and where requested, ongoing support reducing the likelihood of burn out and other mental health issues.

In the future, the information on the number and type of contacts made can be aggregated to identify patterns in events attended and their subsequent impact and will lead to the ongoing design of interventions and health programs to reduce the likelihood of mental health issues developing.

In addition to providing a platform for case management and proactive intervention a lot of work has gone in to assuring privacy and security of data.

To help promote shared learning across the Emergency Services, a new Linked IN group has been created. Please feel free to join the group, which, in conjunction with other members, we will keep up to date with PEER Support content and discussions. If you are involved in Emergency Services PEER Support or have a keen interest in this area, please feel free to join and contribute.



If you would like to find out more about how 2CRisk can help you tackle the challenges of providing effective PEER Support, go to www.2CRisk.com.au or you can contact Mark on +61 1300 736 361 or e-mail markc@2CRisk.com.au

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