Understanding stigma and help-seeking in emergency services personnel for good mental health

MELBOURNE

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1. Background to the Study

Within the emergency services sector, stigma is widely understood to be a key barrier to help-seeking for mental health, however there is a need to gain a deeper understanding as to why this is the case, and how it might best be addressed. The issue of stigma and help seeking was identified as an area of work where funds raised by the 2019 Melbourne Firefighters Stairclimb event could be effectively directed for widespread benefit. In response to this, in 2020, Phoenix Australia was commissioned by the Emergency Services Foundation (ESF) to assist in the facilitation of a Think Tank with sector representatives, focussed on stigma and help seeking for mental health. A rapid review of current evidence and best-practice relating to high risk organisations was conducted and the findings were presented at the Think Tank on 23 April 2020. This was followed by two facilitated discussions to identify current programs and gaps in addressing stigma and help-seeking across the sector, priority action areas, and the generation of options for cross-agency projects(s). This informed the development of the aims for the current project.

The rapid evidence review conducted by Phoenix Australia highlighted that emergency services personnel who are experiencing sub-clinical mental health concerns (e.g., anger, sleep, relationship difficulties) can be at increased risk of developing mental disorders if they do not recognise their symptoms, seek help early and get the help they need. There are a range of possible barriers to help-seeking, including anticipated public stigma, self-stigma and mental health service and agency concerns, as well as a strong preference for wanting to self-manage mental health issues.

There is clearly a need within the emergency services community to provide timely access to mental health services. However, despite considerable investment in mental health programs and services, there is still unmet need and under-utilisation of the available services.

The purpose of this project was to develop an evidence-based, deeper understanding of stigma related to mental health and the barriers or enablers to help-seeking. This information will be shared with Victoria's emergency management agencies and broader stakeholders to drive improved understanding, early intervention strategy development, and implementation of workplace programs and services.

2. Introduction

2.1. Stigma and help-seeking in high-risk organisations

A high-risk organisation is defined as one where there is a predictable risk of exposure to potentially traumatic events and inherent organisational stressors due to the physical nature of work or job demand. This includes military and emergency service organisations.

These organisations have professional and dedicated workforces, and while the work is generally regarded to be meaningful and rewarding, it is also challenging and demanding. Research conducted in Australia over recent years, highlights that high-risk occupations are associated with higher rates of self-reported psychological distress and some mental health conditions than the general community, and that this risk increases as they retire or transition out of these workforces (Forbes et al., 2018; Lawrence et al., 2018). There are also higher rates of suicidal thoughts than in a matched community sample (Forbes et al., 2018; Lawrence et al., 2018), and the rates of completed suicides in ex-serving Australian Defence Force (ADF) members are significantly higher than the rates in the current serving ADF population (Australian Institute of Health and Welfare, 2018).

As well as more severe mental health problems, related issues such as sleep problems, anger and aggression, guilt, social withdrawal and emotional numbing may also occur in high-risk occupations (Forbes et al., 2018; Lawrence et al., 2018). There is substantial evidence that these issues are associated with significant levels of functional impairment and distress in their own right (Judd, Paulus, Wells, & Rapaport, 1996; Karsten, Penninx, Verboom, Nolen, & Hartman, 2013), and represent a risk for further escalation of symptoms and development of disorder with the passage of time (O'Donnell et al., 2013; Pietrzak, Pullman, Cotea, & Nasveld, 2013). Importantly, early mental health symptoms may be less entrenched and more susceptible to brief interventions than fully established mental disorders (Haller & Chassin, 2014; McFarlane, 2017; Scott et al., 2013), and represent an important avenue for early intervention and risk mitigation. However, people may not always recognise these early signs as an indicator of emergent mental health problems. In fact, the Answering the Call report (Lawrence et al., 2018) noted that police and emergency services personnel may not recognise their need for mental health support even where mental health problems were more severe. Therefore, understanding how these populations identify and recognise early mental health issues in themselves and others is an area requiring further investigation.

2.2. Utilisation of mental health services

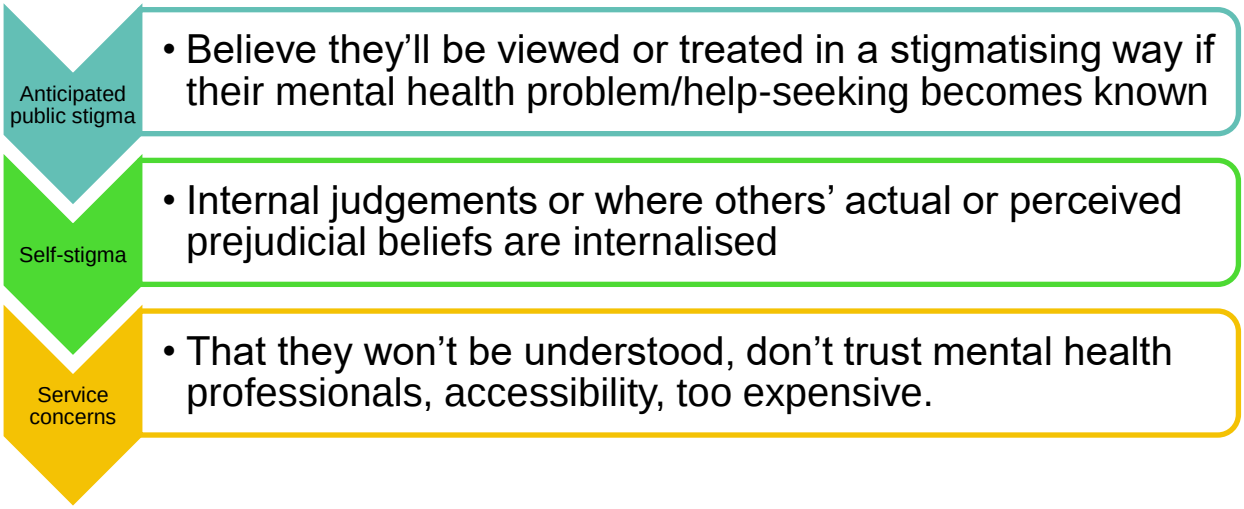
Where an individual does recognise that they have a mental health concern, as is seen in the general community, members of high-risk organisations tend to under-utilise mental health services. [1][2]

[1] Answering the Call (Lawrence et al., 2018).
[2] (Forbes et al., 2018)

Between 30-50% of current and ex-serving ADF members with a mental disorder will not have sought treatment[2]

Only 20% of police and emergency service members with a mental health issue are receiving adequate treatment[1]

There are a range of factors that have been attributed to the under-utilisation of mental health services in high-risk populations including:



When emergency services and military personnel are asked 'what stops you from seeking help?' they describe very similar concerns including: a desire to self-manage, fear of adverse career impacts, fear of being perceived as weak, or concerns about how their leadership / peers will treat them (Forbes et al., 2018; Lawrence et al., 2018; Van Hooff et al., 2018). Notably, the emergency services personnel generally held more stigma about their own mental health than that of others. Although they felt shame and perceived themselves as a burden in regards to their own mental health problems, they reported that they would be supportive of a colleague who experienced a mental health condition. Interestingly, they were also generally less positive regarding how supportive they felt others in the organisation would be towards those with a mental health concern (Lawrence et al., 2018).

2.3. Reducing stigma and increasing help-seeking

Reducing stigma and increasing help-seeking are key features in mental health strategies for high-risk organisations. These have typically focussed on:

- Emphasising that seeking help won't impact your career and how others regard you
- The use of high profile mental health champions who share their personal stories
- Promoting the agency's commitment to supporting people with mental health issues
- Education and promotion on mental health services.

However, despite large amounts of investment in mental health campaigns, evaluation and research both nationally and internationally indicates that these programs have not had a large impact on changing attitudes or improving help-seeking behaviours (e.g., (Acosta et al., 2014; Forbes et al., 2018)).

2.4. What drives help-seeking behaviour?

Recent research on serving and ex-serving ADF personnel has more closely examined their help-seeking behaviours (Benassi, 2020). In this group (N = 11,587), it was estimated that 21% met the criteria for a probable disorder (PTSD, depression or anxiety) in the past 12 months, but only 54% of these self-reported use of a mental health service. The majority (82%) indicated that they preferred to manage the problem on their own. When their help-seeking beliefs were analysed in closer detail it was revealed that:

- Need is a key driver of seeking mental health services, and especially self-perceived need. The individual must perceive that they need mental health services, and that the service will assist them to self-manage their issues. Perceived need was a stronger driver of help-seeking behaviour than levels of work, family or social impairment or levels of symptoms.
- Anticipated stigma alone is not enough to explain under-utilisation of services. There are various types of stigma that influence behaviour and stigma is internalised and more salient when people are unwell. High levels of self-stigma was a larger barrier to help-seeking than anticipated stigma or service concerns.
- Social context also has an impact. When individuals are experiencing high levels of anticipated stigma, self-stigma and /or service concerns, they also tended to report less positive interactions with friends, and social impairment also had a negative impact on help-seeking behaviour.

2.5. Study rationale and objectives

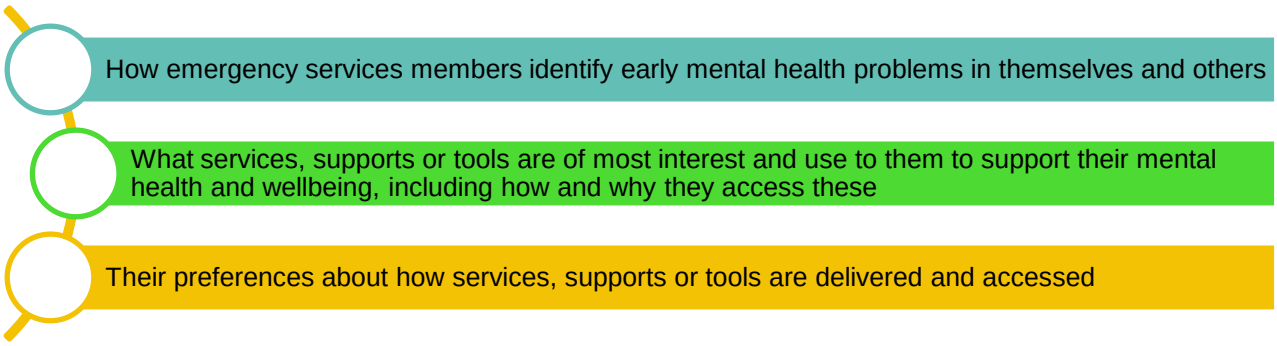
Emergency services members who are experiencing early mental health concerns (e.g., anger, sleep, relationship difficulties) can be at increased risk of developing mental disorders if they do not recognise their symptoms, seek help early and get the help they need. There are a range of possible barriers to help-seeking, including stigma, and a known preference for wanting to self-manage mental health issues. However, despite the clear need within the emergency services community to provide timely access to mental health services and considerable investment in mental health programs and services, there is still unmet need and under-utilisation of the available services. To gain a deeper understanding of this unmet need and under-utilisation of services, the current study aimed to investigate how emergency services members recognise early mental health issues in themselves and others; what types of services, supports and tools they use to help manage these, and how, when and why they are (or are not) used; and their preferences regarding the form or modality of services and supports, and messaging and communications around these.

3. Methodology

3.1. Design

A ‘bottom-up’ approach, where the experiences and perspectives of the target population (emergency services members) are captured and used to inform understanding, was used to compliment what we

already know about stigma and help-seeking from the available research. A qualitative semi-structured interview design was used to understand:



We aimed to recruit participants from a cross-section of Victorian Emergency Services agencies and organisations, including those from operational and corporate roles, and including members who were transitioning to retirement. This allowed for a broad range of perspectives and experiences to be captured. The use of semi-structured interviews allowed the conversations to be structured around our key areas of interest, while also allowing for open dialogue from respondents regarding their own experiences, and the meanings, attitudes and motivations underpinning these.

3.1.1. Co-Design

A key principle underpinning this project was the use of a co-design methodology. This ensured that the ESF and member agencies were engaged in the project and their input reflected throughout the entire project.

Representatives from 10 member agencies: Fire Rescue Victoria, State Emergency Service, Country Fire Authority, Victoria Police, Ambulance Victoria, Emergency Management Victoria, Emergency Services Telecommunications Authority, , Life Saving Victoria, participated directly in this project by providing membership on the co-design group, and/or through their members participating in the research interviews.

The co-design team had the following responsibilities:

- Providing relevant contextual information from their agency, including the range of mental health supports and services available for members
- Ratifying the questions for the interviews
- Assisting to identify methods to maximise diversity in the cohorts, including ways to schedule data collection to allow for shift workers, volunteers etc. to participate
- Advertising the research project amongst their staff and volunteers
- Reviewing the draft final report with a particular focus on the ‘real world’ implications of the findings.

The other ESF member agencies were also given the opportunity to contribute to the project by:

- Commenting on the project design
- Providing relevant sector context
- Proposing tools or services, modalities and/or potential communication strategies they would like participants to comment on during the data collection phase.

3.2. Sample/Recruitment

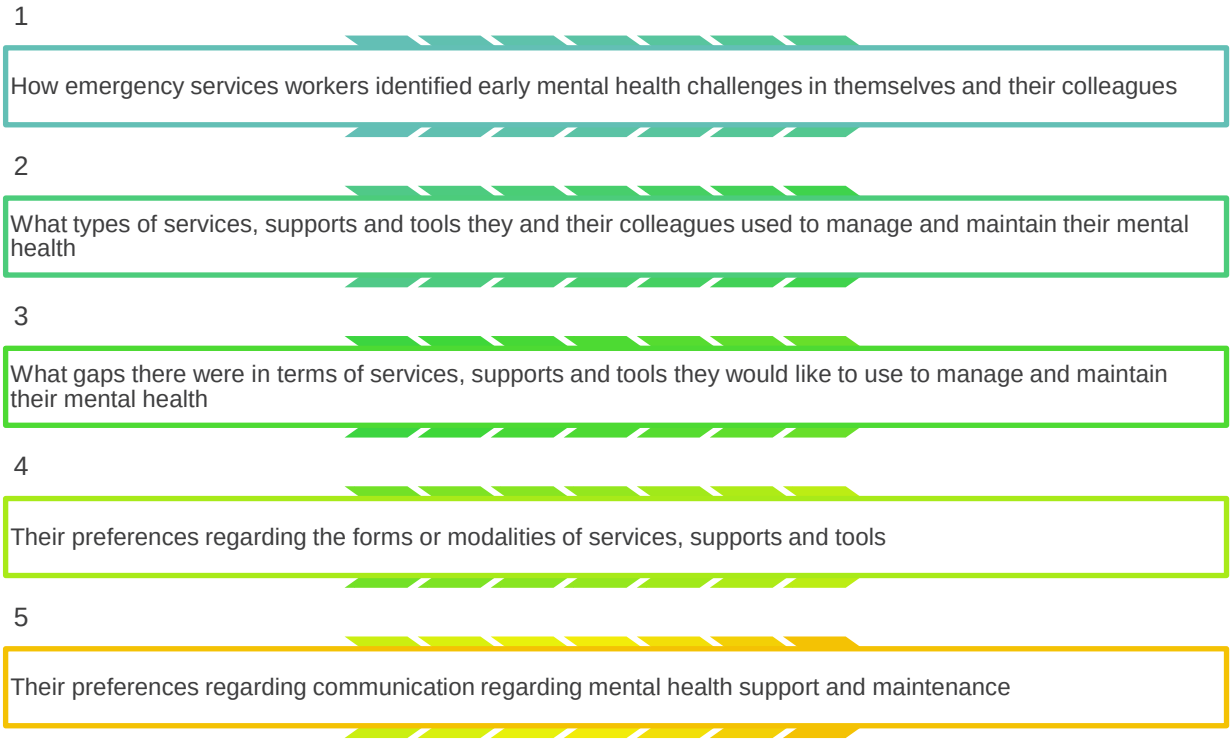
In collaboration with the ESF, as described above, partner agencies were engaged in the co-design of interview questions to ensure our research aims met their organisational requirements of the study. All partner organisations facilitated sharing of study information among their staff, with interested individuals directed to contact the Study Support Coordinator at ESF to express their interest and determine study eligibility. Contact details for interested, eligible participants were provided to the Research Assistant at Phoenix Australia who initiated contact to provide further study information and schedule an appropriate time for an interview over zoom. Participants were offered the option to remain anonymous for the interviews if they wished, and given instructions for applying a pseudonym and turning their camera off. Recruitment continued until saturation was reached at 25 participants. The study was approved by the University of Melbourne Human Research Ethics Committee (HREC Reference: 2020-20383-13285-3).

3.3. Procedures

Informed consent and permission to record the interview was obtained at the commencement of the interview. All interviews were conducted over online videoconferencing platforms and lasted between 20-45 minutes.

3.4. Data Collection

A single Clinical Research Fellow from Phoenix Australia conducted all interviews. The semi-structured interview schedule was informed by existing literature and gaps in knowledge and refined through co-design with partner emergency services organisations. The final interview contained 5 core questions addressing:



These questions were used as a general guide for the interviewer to prompt or seek elaboration on topics of relevance to the research aims, while allowing participants the space to engage in open discourse about their own experiences.

All interviews were recorded then transcribed and de-identified by allocating each a unique identifying number. The concept of ‘saturation’ was used to determine the necessary number of interviews to undertake. Saturation is considered to be reached when all the viewpoints and information about the issue have been voiced by participants, and no new ideas or opinions are being revealed with each additional interview. Initial coding (as described below under ‘data analysis’) was undertaken as soon as possible following each interview to identify commonly occurring and repeated themes. No new themes were emerging after 20 interviews indicating that saturation had been reached. A further 5 interviews that had already been scheduled were also completed, transcribed, de-identified and coded.

3.5. Sample Characteristics

Participants ranged in age from 29 to 64 years, and included members from the following Victorian agencies: Fire Rescue Victoria, State Emergency Service, Country Fire Authority, Victoria Police, Ambulance Victoria, Emergency Management Victoria, Emergency Services Telecommunications Authority, Life Saving Victoria. The sample gender and occupational category details are presented in Table 1.

Table 1. Sample Characteristics

Category	n	%
Gender		
Male	13	52%
Female	12	48%
Occupation category		
Transition to retirement	7	28%
Corporate	10	40%
Operational	8	32%

3.6. Data analysis

The final dataset included 25 interview transcripts, and reflective notes from the interviewer.

A thematic analysis approach was used whereby interview content was systematically examined for recurring information and themes. Two researchers independently coded the first 10 interviews. Initial themes were developed deductively based on the interview framework and key questions, and inductively through listening to interview recordings and reading transcripts. The resulting themes from both researchers were compared, with a coding framework formulated based on agreed themes from both researchers. All 25 interviews were then coded to this framework, with themes refined and modified using an iterative process. A third researcher reviewed the final themes and interview content to ensure themes appropriately and accurately reflected interview content.

In the next phase of analysis, resultant themes were quantified according to frequency, and organised in relation to the key research questions of interest. Following this, themes were further grouped into overarching key themes and where relevant, related sub-themes that logically fitted under the overarching main themes. These were then indexed against direct quotes from the interviews to ensure that themes appropriately reflected interview content.

The themes and sub-themes, organised according to question/area are presented in Table 2.

Table 2. Coding Framework

Question/Area	Themes	Sub Themes
Indicators		
	• Change from usual	General observation that the person was different to 'normal' Change in relation to specific indicators Knowing the person well enough to observe and identify changes Subtle changes may be missed
	• Stigma	Hiding mental health problems due to concerns about judgement or job impacts

Question/Area	Themes	Sub Themes
Services, supports and tools		
	• Informal supports	Trusted others The team Shared experience Peers
	• Formal supports	Cultural competence Tailored support Availability and accessibility
	• Autonomy and self-management	
	• Structures and process	
	• Stigma	Masculine culture Mental health
	• Early and ongoing training and education	
	• Leadership engagement and commitment	
	• Proactive approaches	
Forms of delivery		
	• Multiple modes of delivery and access	
	• Characteristics of good mental health services and supports	Culturally competent Widely available and accessible Include face to face content and options
	• Autonomy and confidentiality	
	• Proactive approaches	
	• Whole of organisation approaches	
	• Sector wide standards	
	• Leadership	
Communication and messaging		
	• The 'Human' factor – lived experience	
	• Leadership	

Question/Area	Themes	Sub Themes
	• Ongoing and embedded	
	• Representativeness and diversity	

4. Results

The following section describes the key themes and provides de-identified illustrative examples taken from the interview participants.

4.1. What are the early signs and indicators of mental health challenges?

Across all interviews, respondents talked about what indicated to them that someone was experiencing mental health challenges – whether that was themselves or a colleague. **The most commonly reported specific signs were, in order of frequency, irritability, anger and aggression, withdrawal/isolation, heightened emotions, reduced productivity and absences (i.e., sick leave) and sleep problems.** Other indicators that were less commonly discussed included increased alcohol use, emotional detachment, and agitation/hypervigilance/overreacting. In addition to discussing these more specific signs, across all interviews, it was clear that the concept of 'change from usual' was how most respondents identified mental health challenges, particularly in others.

4.1.1. Change from usual

4.1.1.1. Non-specific change

This change was often not anchored to anything specific, instead reflecting more general observations that the person was different to 'normal'.

"They go from being someone who has been a high performer, or someone who can manage things effortlessly, to someone who's struggling just with day to day getting things done."

"Don't seem themselves, tired, irritable, not attentive, not participating, not present, look nervous, out of character comments or behaviours."

"Changes in behaviour- their demeanour, approach and decision making … if normally quiet might become angry, if outspoken then might become more insular"

4.1.1.2. Change in specific behaviours/indicators

It was also implicit in the discussion of more specific behaviours or indicators, where respondents discussed the emergence of new or different emotions or behaviours.

> ***"I think the aggressive thing is definitely something that I've come across probably most … that outward frustration that they all of a sudden would snap at something they wouldn't normally react to in the same way"***
>
> ***"I'll be looking for people who are more isolated, listless, depressed, you know, snappy, irritable, that sort of thing."***

4.1.1.3. Knowing the person well enough to observe and identify changes

Importantly, this concept of change could be any change from what was usual, and was very much determined by the characteristics of the individual, and relied on someone knowing them well enough to observe these often subtle changes.

> ***"I've kind of experienced people kind of short tempered or not their normal work personality. So a change in their behaviour … And knowing that person as well as I do, I know that they've got shit going on."***
>
> ***"…observing their body language and tone of voice … It's usually people I know, so observing a change in usual presentation."***
>
> ***"We're very lucky because we do spend a lot of time together so you can see change in behaviour … any change from positive or negative … I'm always very mindful of my crew, and how they're going"***

4.1.1.4. Subtle changes may be missed

However, the subtle nature of changes, and knowing what to look for, can also pose challenges.

"Something that gradually build ups over time … we get used to other's traits and changes but often grow with these changes. Someone who might not have seen them for a while might notice these changes more easily"

"People tend to cover up a lot. So sometimes you don't see the early signs until they've become a problem."

"We work in team environments, so you can actually pick up on it pretty quick. Well, if you're attuned to it"

For the most part respondents discussed what they observed in their peers and colleagues, however, some people also spoke about how changes in their own mental health had been brought to their attention by others. These observations were sometimes reported as a surprise to the person, and at other times they represented an external confirmation or validation.

"I actually overworked myself to avoid certain… an avoidance sort of tactic. And I didn't realise it at the time, of course."

"…it was a magnificent, timely intervention for me. Because my hand was forced at that point in time."

4.1.2 Stigma

A number of respondents also talked about how mental health challenges were hidden due to stigma or concerns about job impacts or judgements from others.

"[There is] stigma around naming struggles with mental health until it's too late, but [they] will talk about fatigue … it's up to members to be receptive and identify that they have the problem and then do something about it and get help"

"if you say you are struggling then you need to show cause that you are ok to [work] … so you put your hand up to ask for help and your job might be affected"

4.2. What supports or tools are most helpful to maintain and manage mental health and wellbeing, and where are the gaps?

The interview content revealed broad knowledge and endorsement of a range of formal and informal supports and tools emergency service workers use to manage and maintain their mental health. While most respondents listed off the supports and services they knew of, suggesting the information regarding their availability is accessible and well known, this 'listing off' also indicated a relatively surface engagement. This was particularly the case for websites and apps which were often mentioned, but usually with a caveat that they were not actually used by the participants or their colleagues.

The supports that respondents did have strong positive engagement with included both the formal supports, such as the employee assistance programs and psychological support, as well as the more informal peer and team support. A common secondary theme that came through in relation to formal supports was around the extent to which these formal supports were 'culturally competent' to their specific emergency service organisation. Where there was a high level of cultural competence, this was perceived more favourably.

Almost half of respondents noted a need for expanded access to culturally aware professionals (e.g., psychologists) both internal and external to the organisation. There was also an identified need for overarching structures through which early mental health issues could be identified and followed up. Some good examples of this specific to agencies were identified, however there was also an acknowledgement that more could be done to have consistent standards across the whole of the emergency services.

The majority of respondents reported a reluctance to seek help related to stigma and the highly masculine culture of the emergency services. There was clear knowledge of a range of useful tools and supports available, including formal and more informal – however stigma still seems to be a significant barrier to using these supports.

In considering how to improve access to mental health supports and assistance, particularly against the background of possible stigma and other cultural and occupational barriers, approaches that allowed individuals to access support in a non-specific way confidentially were viewed as important. Whole of organisation or group based education and training were seen as useful ways to give information without individuals having to publicly express need. There was also a more general endorsement of the need for embedded training and education at all levels of organisations as a means of increasing mental health literacy, normalising conversations about mental health, and ultimately shifting the culture and narrative around mental health within emergency services.

4.2.1. Informal supports

4.2.1.1. Trusted others

When respondents discussed how they manage their own mental health and how they support their colleagues, the importance of trusted others was viewed as central. This included the organisation as a whole, both internal and external support services, the teams within which they work, and their supervisors, colleagues and peers more generally.

"I think it's just, you know, knowing the person and knowing what's going to help"

"Supportive informal supports. [People] who know you well."

"that team mentality and team environment to be able to have those conversations amongst the people that you're comfortable with"

4.2.1.2. The team

The importance of the 'team' arose as a clear theme in relation to identification of early mental health challenges (as discussed above), and as a source of support.

"make sure that you're talking to your crew and talking to each other to support each other and using the services that are available to us"

"I think … we're pretty lucky in the sense that we're always at the same place a lot of the time, so having those relationships I think it's a really good thing to have in place to support each other. So, that social connection, [is] really important I think"

4.2.1.3. Shared experience

The importance of being able to get support from someone who 'understands' and who is trusted is critical. Many respondents talked about how they and their colleagues felt more comfortable speaking with peers or team members, often because they were known and trusted, and because they were more likely to truly understand their experience.

"We have a good social networking, people become very, very close friends. And we talk about those things. And generally during those conversations you pick up if someone's not dealing with something. The brigade family as such"

"Emergency services are a close knit community and seek solace in their own environment because they understand and might also be going through the same thing"

4.2.1.4. Peers

The value of peers was frequently discussed, although some respondents questioned the structures, including qualifications, underpinning more formal peer support programs.

"People would prefer to talk to kind of their peers over a [professional]"

"I don't have confidence in the peer support process … because often they're unqualified"

4.2.2 Formal supports

While informal support from supervisors, teams and peers was seen as central to maintaining mental health, there was an acknowledgement that internal beliefs, and concerns about judgements from colleagues or supervisors meant that sometimes more formal impartial support was needed.

"The 'what if's and 'should have's' is really important … [you] can't say this stuff to your boss, needs to be someone impartial. Need someone to listen and help process without judgement, blame, or interrupting with their experiences. [Someone to] validate your experience. Acceptance and non-judgemental support"

"You want to be open and honest but then you might be audited to see if you are fit got the role you are doing … that makes it harder so EAP as its outside of workplace makes it easier and then improves ability to then walk into workplace to say you need time off."

4.2.2.1. Cultural competence

It was particularly important for these formal supports to have a high degree of cultural competence (agency knowledge) and understanding of the role of the member.

"It just depends I guess where you're going and whether you know you've landed with the right clinician or service that has experience in the particulars of emergency services, and the specific challenges that they face"

"When they kind of make it relatable, then people really opened up … that definitely opened up that conversation for them to be able to talk"

"there was some resistance to speak to anyone from [outside] because they didn't know them"

4.2.2.2. Tailored support

In addition to the need for culturally competent formal services and supports, the need for targeted, occupational/agency specific tailored tools and supports was also identified.

"Apps, posters and bits and pieces [are available] but don't do it well. If [organisations] put money into it and do it well then it would instil confidence in members and they would use the resources"

"I am unlikely to use the app as it is generic"

"[Resources have] to be targeted to gender and age"

4.2.2.3. Availability and accessibility

Respondents also discussed gaps around real or perceived availability and accessibility of services and supports.

"I guess the one concern I have is that if anyone wants to talk, if anyone else wants to talk to a counsellor, that there doesn't seem to be an easy way for that to occur"

"A lot of times you don't get to choose your teams, it's just people thrown together. And then they go back home. And I just don't think there's much support for those people who were in your team"

"I'm not sure you know, the broad spectrum other than what's really visible to us. I'm not really sure what's out there that's accessible to people"

4.2.3. Autonomy and self-management

The concepts of autonomy and self-management in relation to mental health emerged frequently, and highlight the importance of the need for embedded organisation wide education about mental health so that all members know themselves what to look for, what to access, and where to access it.

"it can't be one size fits all … have to let everyone deal with things in their own way, once they know their options"

"Self-awareness of where you're at on the mental continuum is something that we try to promote"

In some cases respondents discussed the ways in which this was already done within their workplace or occupation, and how this facilitated help seeking.

"There is a greater acceptance of people to be able to put up their hand and say, I can't do this"

"Actually reflecting on the stuff that's impacting on us. And just, you know, trying to educate people on having a level of self-awareness … encouraging people to recognise that and that if they have had a difficult call or event that they've managed that that is okay to be upset"

" … it's been drilled into us about making sure we check in on each other … recruits receive all this information right from day dot about our about our support services. So, yeah, it's drilled in …"

4.2.4. Structures and process

Though less commonly discussed, the concept of structures and processes in place to assist members to support their teams and colleagues was mentioned, particularly in relation to addressing unmet or unacknowledged need.

"Need a solid framework/ strategy in maintaining contact with people who have taken leave"

"If we had some kind of facility or ability, where it could be triaged to a specialist who knows, a better organisation, I think that would be very beneficial."

This included the value of formal structures and processes to guide and facilitate organisations to routinely consider mental health.

"I think it would be probably helpful to have some kind of critical policy, I think, for the entire organisation."

"The impacts of the continual stress that people are put under in their day to day operating of our workplaces … [I] just find it quite interesting that we don't do any kind of follow up investigation on that, even if it was like, every 12 months or two years, you would just have a session with … a trained medical professional. [What if] they've got an undiagnosed mental health condition that they haven't understood themselves and recognised or that, you know, their peers haven't picked up, because they're good at hiding that? I think something like that would be a really big value in an entire sector."

4.2.5. Stigma

4.2.5.1. Masculine culture

Underpinning all discussion of accessing services, supports and tools, the issue of the masculine culture of emergency service organisations, stigma about mental health problems, and how these served as barriers to early help seeking, were pervasive throughout interviews.

"You've got to get someone to accept the fact that they need the support. That's always difficult. Like I said, mostly we were blokes. And if we think we've got an issue, we'll deal with it. Sometimes we deal with it by not dealing with it … if you're not suggesting to someone that they've got a mental health issue … it's easier for them to accept."

"We've come a very long way. But there's still a stigma attached to mental health issues, whether we like it or not, particularly in male dominated emergency services, you know, environment where there is that element of bravado where it's seen as a sign of weakness"

"I want to offload it but I want to still own it … it's why we feel we don't need help - we tend to stand above the community, we are the responders- 'I don't need it, … will I lose power and narrative if I seek help, feel like gee I'm a failure."

4.2.5.2. Mental health

There was also evidence of a general reluctance, at both individual and organisational levels, to openly talk about or acknowledge mental health in general.

"For most people within the [service], they won't talk about it but likely quietly know about the resources available. Occasionally someone will prompt others to access these services after a big job, but outside that it isn't really mentioned"

"I haven't noticed a lot of people wanting or reaching for professional help. They might need it but they don't do it"

"In last 10 years [we've been] given access to EAP services but told not to tell anyone if you did use it"

"It's better than it used to be but, I think still, among certain cohorts, it might be seen as a bit of a sign of weakness"

A number of respondents also spoke about the progress made in dealing with stigma, noting that there are still challenges.

"the more you work to erode the stigma around help seeking, the more it just it, it's a gradual thing, I think it's almost like erosion, you've got to do it over time"

"So, you know, we now quite freely speak about … that in the services there are, you know, people of all genders, persuasions and so forth. And it's just the norm. We haven't reset that space yet with mental health"

"I think we're on the right track. I know we're on the right track as an organisation … we're dealing with it so much better than we used to … More about fitness, but also mental fitness. And the messaging is always there."

4.2.6. Early and ongoing training and education

The importance of early and ongoing training and education at all levels of organisations, and the need for mental health care and maintenance to be normalised and prioritised was discussed as central to supporting individuals to manage and maintain their own mental health and that of others.

"I think preparation is the best thing … when I say preparation, it means you know, having the right people in the right roles. And having that, I guess, training"

"And so every workplace is having a weekly welfare, conversation around the injuries and mental health issue"

"Training during recruitment to normalise mental health difficulties."

"when you got declining mental health, these are things you do, but what about when I'm in good mental health, how can I improve that or stay in that space or build even more resilience"

4.2.7. Leadership engagement and commitment

In normalising and promoting mental health care and maintenance, a top-down approach was perceived to carry more weight. A number of respondents talked about the importance of leadership having good training and education in mental health which would filter down through the organisation.

“a more specific leadership package or mandated package that needs to be done by people who come into an officer's role or command role … it's great to have leadership who are on board and want to promote positive mental health or support … the people that can impact that are the leaders of those areas”

“Our take is to try and educate everybody, so that everyone can be across it, but I think maybe just a little bit of a refresher or something a bit more specific to leadership in mental health”

“Should have to do more courses in people management and self-management as you process within the organisation so you can support others and yourself in order to lead effectively.”

“Mental health and wellbeing support from when a person enters [the service] but then again further mental health training if you want to go into leadership position so we can create safe spaces for colleagues”

4.2.8. Proactive approaches

While autonomy and self-management was discussed throughout interviews, a number of respondents also discussed strategies that would remove the onus on the individual to admit need. These would allow for existing stigmas and barriers that impact help-seeking to be ‘bypassed’.

“They don't think there's any barriers to because there is a role function of the welfare officer to actually make the call”

“As a basic rule, our organisation should, you know, give us a welfare check. And that could be just a simple text message”

“I think unless it's putting right in front of them, they won't utilise it for the most part”

“getting people face to face … getting a counsellor in to group educate people rather than single people out”

“you've got to sort of catch it in a way that it's inclusive training thing, and it's for everybody”

4.3. What forms of delivery make services and supports more or less likely to be accessed and useful?

When asked how supports should be delivered, more than half of respondents mentioned the use of combined approaches that would allow for greater personalisation of services and supports. There was also a consistent theme around the need for facilitators to support members to access services and supports, however this needed to also be in the control of the members themselves – autonomy and self-management were important however many respondents mentioned the difficulty in navigating what was available. Again, the theme of embedded education and training emerged.

4.3.1. Multiple modes of delivery and access

Most respondents discussed the need for multiple modes of delivery to allow for personalised support that meets each individuals needs at any given point in time.

"Accessibility and different modes of delivery is key … Delivery of mental health training needs to be across different modes of delivery but more often"

"Need to have apps, websites and in person … Need to give people room to move"

"Face to face is important for me to build that relationship and read body language … Needs to be personalised, confidential and provide options and access"

"The demographic of audience is so important too … You have to provide support to all differently based on their role. A one size fits all won't work"

4.3.2. Characteristics of good mental health services and supports

Respondents identified a number of key features that were particularly important for services and supports, including cultural competence, wide availability and accessibility, and include face-to-face content and multiple modes of delivery.

Culturally competent

"I think that that probably could be more work done for clinicians and support services that are tailored to emergency services"

Widely available and accessible

"Need to be able to access supports when you need it, 24/7"

Include face to face content and options

"For mental illness if you take the person out then the individual might not go searching for help. The person provides compassion, shared experience … Having a person to help you explore online options may be more helpful"

4.3.3. Autonomy and confidentiality

While members overwhelmingly discussed the need for multiple modes of delivery mental health support, and a preference for at least some face-to-face component, there was also recognition that technology was an important means of allowing them to explore help-seeking in an autonomous and confidential way.

> ***"I think online is good, because … it's quite non-threatening, because they're in control of it … they don't have to physically go and talk to someone or, you know, ask the questions in person. I think sometimes people find that a little bit more confronting, particularly if they're just kind of testing the waters and finding out what's there."***

4.3.4. Proactive approaches

While autonomy and self-management emerged as important themes throughout interviews, again there was a recognised value in proactive and assertive top-down approaches in some cases.

> ***"thinking about the hardest days, you know, is there an opportunity that people could just put in their phone number and their name and get a phone call from someone, rather than them having to make the call themselves … How do you reach out to those people and make it as easy as possible for them to get help"***
>
> ***"Good managers will [check in on] staff. But I don't think everybody does."***

4.3.5. Whole of organisation approaches

When discussing modes of delivery, the concept of whole of organisational approaches to training and education again emerged as a key theme.

> ***"leaders to put it out as a general programme … you've got to sort of catch it in a way that it's inclusive training thing, and it's for everybody … when people join, we have what they call foundation skills, which is the basics that they need to be able to operate and be safe in doing it … I think there should be a mental health component."***

4.3.6. Sector wide standards

A number of respondents again discussed the idea of having sector wide approaches to mental health training, education and support. This was often discussed in relation to disaster response situations involving multiple organisations, where it was acknowledged that there was risk that individuals might 'fall through the gaps'.

"If the agencies could team up and have some kind of cross the emergency services sector if there was a central point that was available or you know, a specialised EAP just for the emergency services.

"The only thing that I see as lacking right across the all emergency services, especially in Victoria is that each organisation likes to do it their own way"

4.3.7. Leadership

In relation to whole of organisation and sector approaches, there was discussion of the importance of prioritising, and possibly even mandating mental health training and education to ensure uptake and engagement, particularly at leadership levels.

"[if] I'm asking someone to volunteer and go along to this health mental health session, or this mental health training and so on [and] it's been put out there that there are things that can members can go to, a lot of members just choose not to"

"I think agencies have to own this a lot more … it should be part of the normal training and human resource management processes … I think that there's a lot of, there's still a lot of education to be done in the space of the supervisors at all levels, about mental health"

This leadership engagement sends an important signal that the organisation takes mental health seriously.

"I think if it was coming from the Commissioner and Deputy Commissioner, people that have kind of had that background where they're kind of got that prestige amongst that group of people. I think when it comes from them, and I think them kind of normalising it and saying that it's perfectly normal to be potentially more impactful than if it came from like, the corporate side of things."

4.4. What type of communication and messaging around mental health would be most useful and meaningful?

When asked about messaging and presentation of information about mental health, the majority of respondents highlighted the importance of the need for genuine people with lived experience, who were representative of all members of the organisation. There was also a perceived need for mental health information, education and messaging to be very much embedded within the organisation culture, with single events or awareness 'weeks' considered not useful. A large proportion of respondents noted that messaging and information should be provided in multiple formats to ensure it reaches all. Again, the importance of 'real people' and face-to-face information was highlighted. A smaller proportion of respondents explicitly mentioned the language used, with a preference for mental fitness or wellbeing over mental health.

4.4.1. The 'Human' factor – lived experience

Respondents all talked about the power of hearing real stories, from genuine people with lived experience. People they could relate to, but also representing the diversity of the sector.

"Need real people and colleagues … my boss talking about how they were affected- that's a powerful message … Someone who has been there and done it and pushing the message that you need to look after yourself … Speaking about it from bosses point of view would send a strong message- coming from the top is the catalyst"

"Having that range of people, you know, maybe even talking about 'fail' experiences. Just to get back to that normalising that this is normal, it doesn't matter where you are in the organisation, whether you're the chief down to the, you know, admin person, we all kind of have experienced these things over our lifetimes"

"Having people speak out, I think, is really powerful, rather than just … you could be feeling this, you could be feeling that … I felt this, I felt that I did this, and this is the outcome. I think having that … firsthand account is really important for people to relate to, and go, Oh, absolutely, yeah, I am just like that person. And I've been kind of feeling that way or whatever normalises it"

"Lived experience stories are really important as well … emergency services themselves probably need to be a bit braver in the types of case studies that we put forward"

"Getting the message across without showing people as superheros … need to show their vulnerabilities too"

4.4.2. Leadership

Respondents also discussed the value of leadership engagement and role modelling in reducing stigma about help seeking for mental health, and demonstrating commitment to prioritising mental health.

"There's nothing better than walking the talk from a supervisors point of view"

"By role modelling I've actually given them a licence to get help. Precisely is a sense of strength to go and get help"

"Potential to use the formal hierarchy to help people see that chief is human as well with own vulnerabilities"

4.4.3. Ongoing and embedded

In terms of how, when and where mental health information is presented, there is a need for ongoing embedded messaging and communication at all levels of organisations.

"Need to make discussions about mental health your bread and butter rather one are you ok day per year"

"It has to be input implanted or inculcated or embedded in into a weekly programme, that everyone just does his business as usual to make it a continual topic"

"Needs to have continual messaging, and genuine commitment … a combination/ multi-pronged approach"

4.4.4. Representativeness and diversity

The forms of communication and messaging should be varied and cater to varying audiences with different needs. Using a multi-pronged approach ensures that people in need won't slip through the cracks.

"I think being aware that there needs to be different types of mediums that need to be available to different ages and stages"

"I think it has to be across the spectrum of communication because not everyone hears the message in the same way … I think it would have to be kind of across the broad spectrum just to capture everybody's preferences and styles of communication"

"Need to target all ages and gender"

It needs to also provide detail and specifics about what is available, and why it's useful.

> ***"having a more nuanced and detailed message than just you know support is available and just reach out for help, like that's pretty basic, I feel like that's a message that's being pushed pretty consistently for a decade or so, that's gotten through"***

5. Discussion

Findings from this study indicate that:

- Early changes in mental health are likely to be non-specific, and are often first identified by supervisors, colleagues, peers or other trusted people (family/friends).
- There are numerous tools and supports available to manage mental health challenges within and external to organisations, and in general these are well known and well regarded by members, however members are often not motivated to access or use them.
- Cultural norms and expectations about what it means to be an emergency services worker, and stigma regarding mental health also remain a significant barrier to utilisation of mental health services and supports.
- There is a need for a proactive approach, where mental health maintenance and management is prioritised and valued at an organisational level. This includes agency wide mental health training, education and resources, embedded through all levels allowing for varied modes of delivery and access.
- This needs to be supported by messaging and communications around mental health that are relatable and representative for the diversity of members, and are genuine and ongoing.
- The role of leadership at all levels in this is central.

5.1. Identifying mental health challenges

There are a range of observable indicators of early mental health challenges that are non-specific and often observable to others.

The most commonly reported specific signs were irritability, anger and aggression, withdrawal/isolation, heightened emotions, reduced productivity and absences (i.e., sick leave) and sleep problems. Most often these are identified by others, and in particular it is the change in usual presentation of an individual that signals there may be underlying early mental health issues. The study findings also highlighted the importance of colleagues or trusted others in identifying these early changes, with them possibly not noticed or acknowledged by the individual themselves.

Prior research suggests that while individuals may themselves be reluctant to seek help and feel shame regarding their own mental health issues, this does not necessarily extend to colleagues. The Beyond the Call study (Lawrence et al., 2018) reported that most police and emergency services members perceived themselves to be supportive and non-judgemental of colleagues experiencing mental health issues. Importantly, however, there was a perception among members that *others* within the organisation would not be as supportive of *them* should they have a mental health problem. Therefore, the finding that early mental health issues were most often identified by others is perhaps unsurprising. Emergency services members may be more open to recognising mental health issues in their colleagues than themselves.

This highlights both an opportunity to leverage individuals and teams within agencies as a mental health resource for each other, but also a challenge for agencies to lean into, around normalising conversations about mental health to reduce stigma. In order to leverage the value of individuals who make up emergency service agencies, the agency as a whole needs to be upskilled. This will ensure that all members can appropriately identify risk, and know what the appropriate resources are to direct people to. This also extends beyond the agency to mental health literacy and information for families. Taking a whole of agency approach to addressing mental health, will arm all members with the education, training and knowledge to allow them to better support each other, and will actively demonstrate a whole of agency commitment to and prioritisation of mental health (rather than approaches that rely on 'champions' or nominated welfare officers), which will contribute to addressing the persistent challenge of stigma. This is consistent with recommendations from the Beyond Blue National Mental Health and Wellbeing Study of Police and Emergency Services (Beyond Blue, 2020) suggesting that cultural shifts within the police and emergency services are needed to tackle persistent stigma.

5.2. Managing and maintaining mental health

Emergency services members experiencing mental health challenges know there are services and supports available but they may be uncomfortable admitting need, may not know what they need (or that they need anything), or may not feel that the supports available are appropriate.

These are consistent with the factors identified by Stratton et al (2018) that influenced workers in male dominated workplaces (including emergency services) to disclose mental health issues. These included knowledge about symptoms, concerns about confidentiality, possible discrimination by peers or supervisors, and dissatisfaction with services.

This study also found that emergency services members want services and supports to be culturally competent, tailored and available and accessible. There is evidence to suggest that addressing these in the design and delivery of services and supports is likely to improve uptake and acceptability (e.g., (Johnson et al., 2020).

5.3. Delivery of and access to services, supports and tools

Stigma regarding mental health, and cultural expectations about what it means to be an emergency services worker still represent a significant barrier to admitting need, and to accessing services and supports when they are needed.

The findings indicate that there is a requirement for approaches to mental health service delivery that allow for confidentiality, are proactive when necessary to bypass barriers to admitting need, and support autonomy and self-management with guidance where needed. Leadership support and engagement was viewed as particularly important here in terms of role modelling, and actively supporting team members.

Leadership engagement emerged as a strong theme throughout the interviews in this study. A recent review of training for resilience building in first responders found that of all programs and interventions, leadership training showed the most promise as a mechanism to increase resilience, wellbeing and stress management in first responder populations(Wild, El-Salahi, & Esposti, 2020; Wild, Greenberg, et al., 2020). This includes training in mental health literacy, how to have conversations about mental health with their teams, how to support their staff, and modelling the maintenance and care of their own mental health.

5.4. Messaging and communication around mental health

For messaging and communication about mental health to effectively reach emergency services members, it needs to be genuine, ongoing and representative of their experiences.

Single days or weeks, where mental health is the focus, are not sufficient to gain traction and normalise conversations about mental health day to day. Instead, ongoing information, education and messaging in multiple formats was viewed as the best way to increase reach. Lived experience stories are a key component of mental health communication, and should include representation from all levels of the organisation, and across a range of mental health issues and concerns. These stories provide a meaningful model for members to understand their own experiences and are a powerful means of addressing pervasive stigmas, and cultural narratives around masculinity and weakness.

5.5. Addressing stigma

There is a need for embedded organisation wide education and training but it must be accompanied by communications from real and relatable people with genuine lived experience.

Corrigan (Corrigan, 2016) identifies a number of lessons regarding how to address stigma effectively. He proposes that while education is important and can be useful, it has limited value in affecting change unless accompanied by 'contact' – that is, engagement with lived experience. This contact reduces stigma by highlighting that these people are not the 'other'. This engagement allows individuals to identify with those experiencing mental health challenges, and effectively 'see themselves in that position'. As discussed in the introduction to this report, previous approaches to addressing stigma have used lived experience, however this has typically been high profile 'spokespeople'. It may be that their status or profile serves to reduce the extent to which individuals can identify with them and their experience. In turn, this can undermine the power of their contact and message. There was a strong desire among the respondents in this study for lived experience stories that represented the breadth of emergency services members. People articulated the power of hearing from someone 'like them', and also the value in being able to translate those stories to their own experience. This representativeness naturally reduces the tendency to 'other' those who have experienced mental health challenges, and allows individuals to identify with them, and see themselves 'in their shoes'.

A recent systematic review of continuum beliefs and mental illness stigma found that interventions using a continuum model should accompany this with approaches that address 'othering' and allow users to identify with experiences along the full continuum of life experiences (Peter et al., 2021). One example of the use of contact in mental health education in first responder occupations, is the Road to Mental Readiness (R2MR) program, an early intervention program designed to reduce mental health stigma and increase resilience among first responders (Szeto, Dobson, & Knaak, 2019). A recent meta-analysis of outcomes found that it was effective over the medium term and also contributed to shifting workplace culture (Szeto et al., 2019). This program uses a contact-based model of education, with lived experience stories and peer facilitation. Other approaches that address the issue of personal identification with experiences of mental health challenges or mental illness include digital interventions that use gamification, and allow users to virtually experience the continuum of mental health.

Where many stigma reduction programs have focussed on highlighting and promoting that organisations support people with mental health issues (Acosta et al., 2014; Forbes et al., 2018), findings from the current study indicate that this is not enough. Looking after mental health needs to be normalised and prioritised, and role modelled by leaders at all levels, and there needs to be a sense of organisational solidarity in addressing this. Most respondents in the current study discussed the need for mental health maintenance to be business as usual – something that is taken care of at all levels of the organisation, and prioritised, but does not require individuals to single themselves out, because this in itself can be stigmatising. Reducing stigma is a process, as one respondent put it: 'it's like a process of erosion'. Part of the erosion of stigma is to make mental health care part of best practice within agencies.

A suggestion as to how the stigma regarding mental health can be effectively tackled emerged in discussion of cultural change within organisations, and improvements that have been observed in recent years at the level of individual agencies. These centred around the benefits of an increased focus on diversity and inclusion, and more specific improvements in training, education and processes aimed at managing and maintaining mental health. The success of organisations in embedding diversity and inclusion as core elements across organisations from policy to practice provides a model for how mental health stigmas might be addressed. This starts with acknowledgement at a sector level of the importance of the issue, where mental health care is considered a necessary element of successful and socially acceptable and responsible workplaces, and includes policies and practices and training and mentorship throughout all stages of a career that actively and explicitly address mental health care.

5.6. Implications and conclusions

- **The mental health of all members of agencies is a shared responsibility.** Teammates/colleagues/immediate supervisors and trusted others are in a unique position to identify mental health risk, are an important source of support and assistance, and play a role in facilitating help-seeking. The importance of team leaders in particular, developing trusted and genuine relationships with their team members, should not be underestimated. Therefore, it is critical that all members are armed with the knowledge about how to identify risk in themselves and others, and how to facilitate engagement with services and supports to manage mental health challenges.

- **Stigma regarding mental health, and cultural expectations about what it means to be an emergency services worker still represent a significant barrier to admitting need, and to seeking help and support when it is needed**. A key component of addressing this stigma is for agencies and the sector to normalise and prioritise mental health management and maintenance at all levels.

- **There is a desire for mental health training, education, resources and messaging to be embedded at all levels of agencies (representing all), from recruitment through to retirement** – this will upskill the collective workforce to ensure people understand what to look for in themselves and others, will allow all staff to be facilitators of help-seeking, and will signal a prioritisation of and commitment to mental health care as a critical component of healthy workplaces.

6. Recommendations

6.1. Sector level:

In order to support agencies within the emergency services sector to prioritise and embed consistent best practice around mental health education, training and resources, there is a need for sector wide standards, and consistent core messaging. A sector wide approach will also address existing stigmas through the acknowledgement at a sector level of the importance of mental health care as a necessary element of successful and socially acceptable and responsible emergency services workplace. It will provide a core framework for development of policies and practices, and training and mentorship, throughout all stages of a career that actively and explicitly address mental health care.

- **Recommendation 1: Consideration of a sector level strategy and framework for best practice in mental health education, training and resources in emergency service organisations.**
  - This strategy and framework should allow for the tailoring of approaches, education, training and resources to align with each agencies specific needs and culture.

- **Recommendation 2: Development of an inter-agency lived experience program.**
  - Lived experience stories are a valuable and powerful tool for messaging and education, and stigma reduction, and should be regularly incorporated into communications about mental health.
  - There is a need for appropriate guidelines, training and ongoing support systems to ensure the safety and wellbeing of those who share their stories and for those receiving them.
  - Engagement of members with lived experience in the co-design of consistent core messaging across the sector.

6.2. Agency level:

In order to ensure that individuals who make up emergency service agencies can appropriately identify risk, and know what the appropriate resources are to direct people to, the agency as a whole needs to be upskilled. This also extends beyond the agency to mental health literacy and information for families. Taking a whole of agency approach to addressing mental health, will arm all members with the education, training and knowledge to allow them to better support each other, and will actively demonstrate a whole of agency commitment to and prioritisation of mental health, which will further contribute to addressing the persistent challenge of stigma.

- **Recommendation 3: Mental health education, training and resources should be embedded across all levels of the agency.**
  - This should start early in the career (at recruitment) and be ongoing throughout the career, targeted appropriately to the role and career stage of members.
  - They should be adapted to be appropriate for each agencies unique needs and requirements, but be evidence informed and underpinned by best practice.
  - Education and training should be regularly reinforced and refreshed.
  - Access to mental health awareness materials and information on the support services available should be extended to family members.

- **Recommendation 4: Agencies should consider mandating mental health and leadership training at all levels of leadership.**
  - This needs to be done in a way that is sensitive to the job demands and requirements already in place.
  - It should be given the same attention and priority at an organisational level as physical health and other job requirements to ensure it its legitimacy.
  - This training and education should provide specific guidance on how to build genuine, safe relationships that allow mental health and wellbeing to be integrated into conversations.
  - There should be provision of ongoing support and mentorship to leaders around their role in supporting mental health and wellbeing.

- There needs to be clear messaging around the benefits of mental health training and education for leaders and organisations.

➢ **Recommendation 5: Information about, and access to, services, supports and tools should be easily and confidentially available across multiple platforms.**

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