FINAL REPORT

Emergency Services Foundation (ESF)

A qualitative study to inform the design of a Residential Wellbeing Program for emergency services workers - paid and volunteer

17th May 2023

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Executive Summary

Right Management was engaged by The Emergency Services Foundation (ESF) to co-design a qualitative study exploring the perspectives of emergency services workers and volunteers to inform the design of a Residential Wellbeing (RWP) pilot. The interview outline was co-designed by Right Management and ESF, with input from Dr Shannon Hood a clinician employed by ESF who has a strong interest in the RWP.

ESF sourced study participants through their network. Participant recruitment coincided with Tony's Trek, a solo 1500 km walk by the ESF Chair to raise awareness about the toll emergency service work can take on employees and volunteers and to raise funds for the RWP pilot. Many participants were referred from events and conversations associated with Tony's Trek. Thirty-eight interviews were conducted via phone and video conference in April and May 2023. They were provided an overview of the proposed RWP in advance of their interview.

Key findings included:

- Study participants were overwhelmingly very positive about the proposed Residential Wellbeing Program (RWP) pilot seeing it as a great initiative that filled a gap in existing services and support available to emergency services workers – both paid and volunteer.
- The challenges of emergency services work are diverse, and many did not consider their reaction to individual traumatic events as the biggest challenge or frustration of their role. However, these events and their cumulative nature often had an adverse effect on their mental health and sense of wellbeing.
- Some respondents reported having previously accessed support services to deal with the challenges of their role, though many had not.
- Respondents advised that clinical services worked well when the supporting person had appropriate trauma expertise and emergency services sector experience.
- Negative experiences of clinical services related to wait times, lack of fit and appropriate experience and expertise of service providers.
- Other key barriers to seeking professional assistance include stigma and concerns about confidentiality and potential career impact.
- Most respondents stated that from the RWP they would hope to gain a toolkit of practical strategies they could utilise moving forward, a number were keen to build a support network, and many hoped for follow-up and ongoing support after the program.
- Indicators of program success included greater ability to cope and handle stress, improvements in their mood, relationships, sleep patterns and energy levels.
- A range of views were expressed about how individuals would gain access to the program and the applicant prioritisation processes, and these were acknowledged to be difficult and sensitive issues requiring expert advice and design.
- The majority felt strongly that individual participants should not be expected to make a personal financial contribution to the cost of the program and that instead the agency or sector should fund the program beyond the pilot given that workplace stress was typically the primary cause of people being in the orange zone on the mental health continuum. A small number of study participants suggested that funding should also be sought from other sources including the private sector.

Conclusion

The study reiterated the findings of earlier work around stigma and help seeking. These study participants saw the proposed RWP as meeting an existing gap in early intervention service provision, and through its design will address barriers to early help seeking for people in the orange zone who too often wait until they are severely ill to seek the support they need.

Right Management recommendations for consideration by ESF and the clinicians designing the RWP include:

- The program must be facilitated by professionals with deep sector expertise and a trauma informed approach and include group work plus individual access to facilitators.
- Police and volunteers may need separate programs due to the perceived unique needs of those groups.
- Timing of a volunteer pilot needs to be carefully considered; a weekend may be optimal to minimise time away from paid employment.
- Location of programs need to be mindful of the participant's work and home location.
- The application process will need to be carefully and sensitively managed. Those whose applications are unsuccessful should still be offered an alternative resource/support.
- The referral and prioritisation process requires careful consideration and specialist advice. Self-referral with professional validation is recommended.
- Follow up activities should occur beyond the program to ensure real change is achieved for participants.
- Participants expect to leave the program with a tool kit and strategies to self-manage.
- Pre and post assessment would be useful to demonstrate the tangible benefits of the program and return on investment to justify ongoing resourcing of the program.
- Confidentiality of program participation needs to be carefully considered given concerns from many about potential adverse career impacts if they were perceived as requiring mental health support.
- Participants from the paid workforce should not be expected to take their annual leave to participate in the program.
- Consider accessibility for people with significant caring responsibilities and offer one pilot program specifically for this group to test a different delivery model
- There is a clear lack of appetite from the vast majority of participants to contribute personally to the program costs.

Context

ESF is a not-for-profit bringing together fourteen Victorian emergency management organisations to work collaboratively to help prevent mental injury. Emergency management work is inherently high risk which is why ESF seeks to get ahead of the mental harm and threat with a focus on prevention and early intervention.

ESF leads initiatives that translate research into innovative evidence informed practice and programs that can benefit people sector wide in Victoria. One of those initiatives is a Residential Wellbeing Program (RWP). This has been identified as meeting an early intervention gap for the sector.

The RWP proposed by ESF is a trial is based on a Canadian program which has had remarkable results at both the individual, family, and organisational levels. Whilst based on the Canadian model, ESF's program will be tailored to meet local needs. This study will help to inform ESFs program design.

The RWP is a prevention and early intervention initiative which will target people who are sub-clinical i.e., they would consider themselves to be in the orange zone of the mental health continuum and functioning effectively day to day. It is not a treatment program for people who are already diagnosed with a serious mental injury. It is for people who sometimes feel 'wobbly'. There will be a screening process as people enter the program to ensure anyone who requires treatment is directed accordingly and to ensure participants are in the orange zone.

- **Red zone** interventions be described as services. This tends to be how emergency personnel think of EAP, psychologists/counsellors, Responder Assist Helpline etc. To be more explicit we might call these 'clinical services' or 'therapeutic' services. 'Clinical services' would accentuate the notion that people in the redzone are displaying symptoms of sufficient intensity that they would fit criteria of mental disorder that would be clinically diagnosable.
- **Green Zone** interventions are primarily educational in nature. Words such as 'education', 'training' or 'equipping' might be equally suitable. By definition these are entirely prevention focussed. Examples include Psychological First Aid training, self-care, Mental Health First Aid, and psychoeducation.
- **Orange zone** interventions are the focus of this program. They serve two purposes 1) a preventative function to avoid entering 'red zone' AND 2) a restorative function to return the individual to green.

It is anticipated that the RWP would involve small groups of 8–10 emergency management personnel at any stage of their career coming together over 4 days with trauma experts in a rural residential setting. Whilst this is only going to reach small numbers, it has the potential to be life changing for them. The RWP will be a safe space where participants can listen to others and share their own experience of how the work environment has affected their wellbeing. It will enable them to understand how the brain processes accumulated trauma and how it can affect thinking and reactions.

At the core of the program is the sharing of story. Sharing involves both telling and listening. Most clinical services include storytelling, but it is one-directional. The 'client' tells the clinician their story. This is generally helpful but there is no exchange. The lived experience program will also no doubt be beneficial as it enables listening to the story of others, promoting normalisation and possibly reducing stigma but. listening to pre-recorded lived experiences are equally one-directional and designed only to inspire people to take the next step to seeking help. The RWP is unique in so far as it facilitates the mutual (two-way) exchange of story.

The program will be facilitated by specialists to ensure the storytelling is constructive. The residential nature of the program builds psychological safety amongst the group – an essential ingredient if people are to go beyond the humorous war-story and enter the realm of the vulnerable personal story.

This is a unique program for emergency management workers informed by significant research. ESF is currently fundraising through Tony's Trek to enable it to pilot a RWP with 6 cohorts which will be based on the Canadian (BC) First Responder Resilience Program

About the study

The Emergency Services Foundation (ESF) engaged Right Management to conduct a qualitative study on their behalf to understand perspectives of emergency services workers and volunteers about how a residential wellbeing program could be designed to best support their needs.

The study explored the following perspectives:

- What people find most challenging about their emergency services roles.
- How people are impacted by their emergency services role, including their mental health.
- Previous experiences of accessing wellbeing and mental health support.
- The barriers people face when seeking help.
- Program aspirations from potential participants - what they hope to get from a program and success factors.
- The referral process and prioritisation given the limited availability.
- Program funding post pilot.
- Design considerations including addressing attendance barriers.

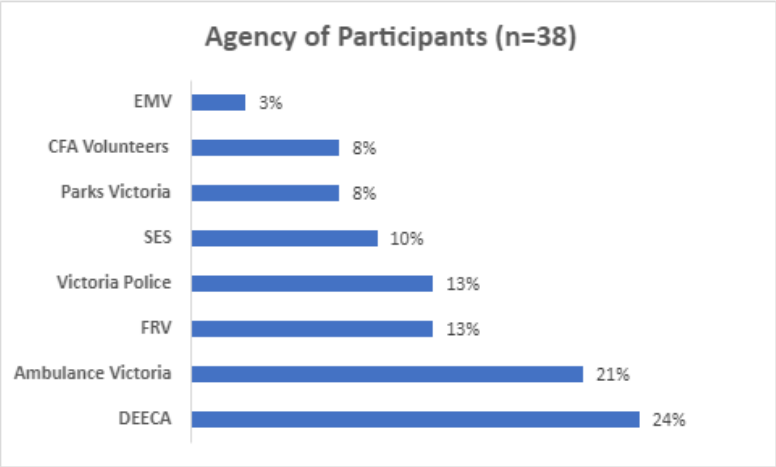
Study limitations

This was a qualitative research study. The sample of career and volunteer emergency services workers was not a random sample and may not be representative of the experiences of all emergency services workers. A disadvantage of snowball sampling is that the sample can be biased to a specific type of respondent. Given the networks through which recruits were selected, it is possible that the study sample was biased to more active career and volunteer emergency services workers.

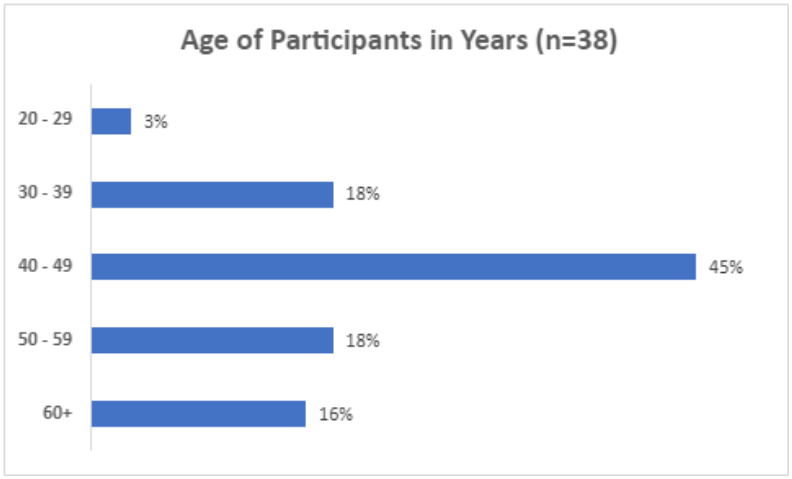
We recognise that 38 interviewees are far from a representative sample of the career and volunteer emergency services workers. However, the strength of qualitative research is measured by the strength of understanding gained through in-depth discussions which generated powerful insights into the needs of emergency services personnel regarding mental health support and how a residential wellbeing program could most effectively meet those needs. The researchers believe that saturation was achieved in many key areas because whilst each member's experience and journey was unique, common themes emerged, and towards the end of the study were iterated without new themes arising.

About the Study Participants

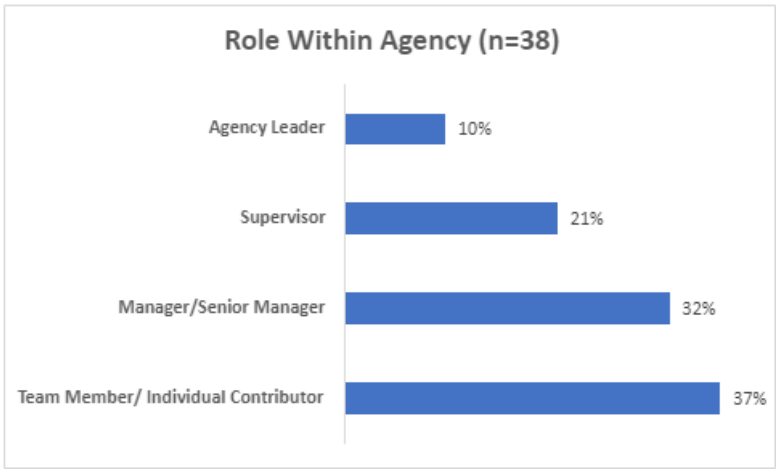
A total of 38 individuals participated in the study, 61% males and 39% females. Participants came from a broad range of agencies including Emergency Management Victoria (EMV), Parks Victoria, SES, Victoria Police, Fire Rescue Victoria (FRV), Ambulance Victoria and DEECA. Most were from the paid workforce but 3 were volunteers for the CFA.



Two thirds of participants were based in regional Victoria with remaining third in Metropolitan Melbourne. Participants ages were quite spread with the largest group in their 40s. Two thirds of participants said that they had dependant/ school aged children.



A variety of role types/levels of seniority were represented, and the largest group (over one third) were team members/ individual contributors.



Most participants were long term members of the sector; 42% had been in the sector for more than 20 years, 39% for 10-20 years and 19% less than 10 years.

Challenges of Emergency Services roles and mental health impacts

A diverse range of challenges were reported and interestingly most respondents reported their biggest challenge was not related to responding to traumatic events. Respondents' biggest challenges were frustrations with workplace politics, and workload including the amount of paperwork, resourcing issues, bureaucracy and logistical challenges.

Many reported that some aspects of their role had an adverse impact on mental health. The majority noted a decline in their mental health ranging from feelings of stress and anxiety through to PTSD. Respondents reported feeling fatigue, isolation, burnout, and anger. Responses in relation to mental health impacts varied from being short tempered and snappy at home through to significant mental health impacts requiring ongoing professional psychological support.

Some members spoke about the negative impacts on their mental health as a result of their first responder role and attending traumatic events, particularly if the people involved were known to them which was more prevalent in regional locations. This was especially so for those who attended emergencies such as bushfires, road accidents, fatalities (e.g. drownings, suicide etc).

Some members stated their firm belief that mental health impacts as a result of their work should be considered a work-related injury.

Some respondents outlined the impact of shift work on their work life balance. They also reported negative flow on consequences from shift work on their health and social life. A small number reported providing peer support to their colleagues which resulted in feelings of emotional strain further exacerbating the impact of work on their mental health.

"I am part of peer support so also get a lot of problems 'dumped' on me which can be frustrating and sad".

Views about the Residential Wellbeing Program (RWP) pilot

Study participants were **overwhelmingly very positive** about the proposed Residential Wellbeing Program (RWP) pilot. Many said that they thought it was a great initiative that filled a gap of existing services and that there is nothing like this currently available to emergency services workers – both paid and volunteer. Several people mentioned how valuable it will be to have a program for *"people in the middle"* before they drift beyond the orange zone into the red zone.

Some said that program participants would then be able to **share personal learnings from the program with their team members** back at work. Some peer support people and leaders said it would be another valuable avenue of support they could refer people to.

Several people said that it would be great if **program attendees became advocates for the program** and discussed the benefits with others, or even went on to deliver peer support services to others. A number said that they would experience the benefit even if they didn't attend. Many felt there would be a positive impact felt across the board for all emergency service workers, due to feeling that their wellbeing was being prioritised as shown by the sector's investment in this program.

Past experiences of accessing clinical services

Most respondents reported having accessed services at some point in their career due to the challenges of their role. The services accessed included formal peer support, EAP, privately funded psychologists, and chaplains; the most frequently accessed service was peer support. Many reported that they needed to access several services to find the best fit for their individual circumstances and needs.

What worked well with the service?

Respondents advised that services worked well when they were able to find a professional that they felt was a good match for them and their needs, someone who they were able to relate easily to and build rapport and trust with. Respondents advised that services worked well when the supporting person had appropriate trauma expertise and emergency services sector experience.

It was frequently stated that their preference was for services provided by a professional with trauma expertise and emergency services sector experience. One respondent advised that their first psychologist had limited experience working with emergency services employees and their session was interrupted by the need to stop and explain terminology which impacted expressing their thoughts and emotions. When they started seeing with a psychologist with experience in emergency services, they were better equipped to address their issues. Numerous respondents indicated they would feel more comfortable talking to someone who could understand and relate to what they were talking about.

Several respondents indicated a preference for in-person services. They felt that the services received face-to-face had been most effective especially in the early stages of service provision. It was also noted by several respondents that when the service provider came to the work site regularly and built rapport and trust, the service provided was more effective. One respondent spoke about the benefits of a trusted, easily accessible chaplain who had become ‘part of the furniture’ because he came to the work site regularly.

Some respondents stated that they found services most effective when they initiated the service request themselves, when they were ready. This supports the need for self-selection in the RWP participant recruitment process.

What didn’t work well with the services?

The main things that didn’t work well were the lack of face-to-face service availability and wait times, the expertise of those providing the service being inadequate at times and funding cuts that led to changes in providers which limited the ability to build rapport and trust. This supports the intensive face-to-face model of the proposed RWP.

Many respondents reported **wait times for services** as a significant challenge, particularly those in regional locations with a preference for face-to-face services, unless you were willing or able to privately fund the services. Two respondents from Ambulance Victoria noted that there was a 6 month wait for services via VACU.

Many noted the lack of clinicians with the required **industry experience** to provide effective services.

One respondent discussed **continuity issues** impacting service effectiveness as they had a different counsellor each time which meant re-establishing rapport. They believed this was due to funding cut that resulted in an end to service provision.

A consistent theme that emerged was the **expertise** of the professional/clinician. Many respondents advised that where the clinician/ counsellor/ psychologist didn't have knowledge of the emergency services and / or experience dealing with the complexity of the issues, the service didn't work well or needed improvement. This reinforces the intention for the proposed RWP to be facilitated by professionals with deep emergency services experience.

Barriers to accessing clinical services

There were three main reasons reported as the barriers to seeking out professional services; stigma, previous negative experiences of services provided, and concerns about confidentiality and career impact of participation. The RWP model will need to overcome these barriers in its positioning and promotion including highlighting that it is a wellbeing program targeted at people in the orange not the red, facilitated by professionals with deep sector expertise and that confidentiality of participation is assured.

Stigma: Many respondents indicated that whilst there have been improvements there is still a perceived stigma for some when it comes to accessing mental health services. Several stated that there is still a culture of "she'll be right" and that many people may underestimate the mental health impact of their work and their need for services. One respondent noted that perhaps there is a culture in emergency services of helping others than helping oneself.

Perceived support quality: Another key reason reported for not seeking professional services was the poor quality of previous services experienced. Many reported that if they had a poor experience previously or knew of someone who had a negative experience, this reduced their likelihood of accessing services.

Confidentiality: The third main barrier was concerns around confidentiality; how seeking professional services might impact their fitness for work and be 'used against them' and that going on the record might limit their opportunities for career progression, perhaps even their ability to perform their current role. One respondent stated they had a genuine concern that if they put their hand up and say that they are in the orange that this might impact their medical clearance / fit for work status. Another respondent stated their concern about obtaining insurance in the future.

Aspirations for the program from potential participants

The key things that study participants reported they would hope to gain from a RWP were a toolkit of practical resources, a support network, normalisation of how they are feeling, time away to stop and reflect; and follow up/ongoing support. Most respondents stated that they would hope to gain a **toolkit of practical resources and strategies**, ranging from self-care tools through to coping mechanisms and strategies for dealing with stress and traumatic incidents.

Several respondents stated they hope for **a support network** to feel like they are not alone. They indicated that it would be beneficial to **normalise how they are feeling** and knowing there are others in emergency services struggling with their mental health and the impacts of the role.

A few respondents indicated a desire for the program to provide them with **time to stop and reflect**. Many people mentioned the desire for program participants to be able to have two-way dialogue, **sharing stories and listening to the stories and experiences of others**. They also stated a preference of a combination of group work and one on one work. One respondent hoped the program would provide them with a mental health diagnostic evaluation.

Many respondents articulated preference for **follow-up and ongoing support** post the program. They stated a desire for ongoing check ins and supports. One respondent advised hoped there would also be training and support for managers and peer support so that the support network around them would be in place after the program.

Evidence of program success

Participants were asked "*If you had attended the program, after the program how would you know it had been successful? What would be different for you after participating? For example, some might say:*

- *I wouldn't be as grumpy with my kids, or*
- *I would have fewer arguments with my wife, or*
- *I would spring out of bed with more vigour in the morning etc."*

Although there were respondents who found this question difficult to answer, a high number commented that success indicators included improvements in their mood, relationships, and energy levels.
Elaborating on the **improvement in energy levels**, some said they would feel reinvigorated and see improvements in their positivity and mindset. Sleep challenges were mentioned frequently and sleeping better would be an aspirational outcome.

In some instances, respondents pointed to a **toolkit of strategies** they could take away and use ongoing; strategies to help maintain wellbeing beyond the duration of the program, tools to pick up on red flags and techniques to manage issues before they became problematic and mental health shifting towards the 'red zone'.

Several respondents spoke positively of the opportunity to apply these skills and leverage learnings to **help colleagues and family members**. The desire to **reduce the stigma around mental health** and foster a culture change was raised in a number of interviews.

Connection was raised by a few respondents - to **feel they were not alone** in their experience and to help others feel they are not alone. Some mentioned an **ongoing support network** as a desired outcome. Selected quotes are provided below.

I would be better able to pick up on red flags.

I would enjoy work again and not be scared of going to work.

I'd feel less overwhelmed or have the ability to bring myself back if feeling overwhelmed.

More able to pinpoint when I am getting past the yellow zone rather than already in the red.

I'd be less grumpy with my wife and kids.

I'd have better sleep patterns.

I'd come out more positive. A better mindset to make better decisions re time management. Feeling not alone - you are not the only one experiencing this. Help with boundaries, especially with supporting colleagues and peers.

Feeling like I can tackle the day. Not getting too exhausted. May not notice immediately. Others might notice the difference in you - feedback from others

Less fatigued or snappy and feel like have some happiness and energy back.

A pre and post survey - general workplace and / or life satisfaction would show improvement. It would be measurable.

Program referrals process and applicant prioritisation

There were a broad range of responses to this question and most respondents acknowledged this is an **important, complex area** without a simple best approach. The word 'tricky' was used by many.

Simplicity and minimal bureaucracy were highlighted by several as paramount and most felt that self-nomination or referral via the EAP (or equivalent) or Manager referral was the appropriate channel. Agreement and consent from the participants was typically viewed as essential.

One respondent shared a previous experience of having been nominated, along with several colleagues for a mental health program without forewarning. The two-day program dealt with some confronting topics and there was a notable drop-out rate and agitation due to the referral without participant buy-in.

Some respondents felt there were benefits to nominating people without their prior knowledge or "**mates referring mates**"; some suggested it can be the *"quiet ones"* who might not otherwise put themselves forward and this could overcome them missing out on much-needed support. The risks of a non-consultative nomination were also raised with potential for feelings of betrayal and one respondent highlighted that it could *"heighten paranoia of people who are already vigilant*". Another flagged that *"People who are in the orange may not handle being told to go because they are in the orange"*.

A range of risk factors and considerations were highlighted including:

- **Confidentiality**: Fear that mental health issues might become known and that it could be used against them.
- **Equity**: Fairness and equal access across agencies, allocation of places should be proportionate to size. Suggested a campaign so everyone has a chance to learn about the program so they can self-nominate.
  Volunteers: May not have access to the referral options available to paid employees.

Limitations with various referral channels include:

- **Self-referral**: Need to be at the point of acknowledging help is needed; those who self-nominate may not be the most in need.
- **Manager referral**: Not all managers have close relationships with their team members and would know where their team members are on the mental health continuum. Young crew might be afraid to speak up or be worried about approaching manager, not wanting to be seen as not coping.
- **EAP referral**: EAP often is not contacted by people until they're in or close to the red zone.

Applicant prioritisation for program participation

Prioritisation of applicants for program attendance was recognised by study participants as **a sensitive and complex matter given that placements will be limited**. Several people felt those in greatest need should be prioritised through some form of screening process.

Suggestions to assess need included **triage or interview with a specialist or mental health professional** or expert review panel. Others mentioned a questionnaire, or 360 review process which reports on how you view yourself and how others around you view you enabling another party e.g. manager, referrer, family member or friend could provide feedback used to prioritise need.

Potential **waitlists were flagged as a concern** and the risk of raising expectations as an undesirable scenario. One respondent said that agency commitment would be required to ensure that waitlists were minimised. Several highlighted risks for those who self-nominate and said there should be support offered - at least some kind of confidential check in regardless of whether they can access the program. Also emphasised was the need for well-considered messaging around why an application was unsuccessful which provides other support options and timeframes.

Program funding

The vast majority felt that **the agency or sector should fund the program** because the job is the cause of them being in the "orange zone". One stated that if the mental health issues were due to personal circumstances there might be scope for participant contribution, but many said that regardless of whether mental health issues are due personal or work-related challenge, the participant should not be required to pay. Some respondents felt very strongly against any form of participant contribution and one leader expressed: *"No way should it be self-funded as it would add to organisational betrayal".* A team member shared: *"We are doing a job that a lot of people won't do and if they can't see the value in that. They are asking a lot of us. It's a very thankless job".*

Further considerations relating to participant contribution centred around **paid employees not having to take annual leave from work.** Volunteers would likely need to take annual leave from any paid employment and the self-employed would face loss of earnings. If paid emergency service workers were required to take annual leave or lose sick leave entitlements, then some felt that this would be viewed as similar to having to pay to attend.

A small minority of study participants said that a participant contribution would be reasonable, suggesting that the amount contributed should be minimal i.e. to 10-20%. Some said that **participant contribution would help secure buy-in** and one shared: *"if people pay, they go, if they don't pay, they don't value it and may not turn up".*

Another felt that a participant contributing towards the program would be **similar to an investment in professional development** or paying to attend an international conference. Several felt that any participant contribution would form a barrier to attendance, and one said, *"the cost would be too great to individuals at early career stage or if they have kids."* A number reinforced that there are many emergency services workers who are not in a financial position to contribute and if living on a tight budget, would not prioritise themselves if a financial commitment was involved. Some volunteers said that if volunteers had to pay they would not attend.

When the UK Police pay cycle deduction model was discussed, a small number stated that they would be willing to contribute towards others attending. One leader from Victoria Police stated that he feels similarly about contributing to a program as he does to paying Union fees - they pay around $1,000 per annum for Union fees and in a lengthy career he has not accessed this service but is happy to contribute should it be required and for others in need to benefit. Another leader also said they would be happy to contribute out of their pay to help others. This was not the predominant view, one team member said *"deducting money from people's pay for this would not go down well with the Ambo's."*

In terms of agency funding, one model suggested was to disperse the cost through the agencies (e.g. DEECA pay for their own staff), however concerns were raised about funding due to other financial commitments. One leader felt there would be no Government funding available for the next 5 years and questioned the benefit for external sources to invest.

In regard to the option of non-agency contribution, **charitable or sponsorship funding** was raised, and many felt there was value in exploring this option. One regional respondent with Rotary experience flagged that this option may be a challenge due to fundraising challenges and a shortage of volunteers. Suggestions in addition to Rotary were corporate sponsorship. Other suggestions included not-for-profit, Union, Department of Veterans Affairs, service clubs, Minderoo foundation (Twiggy Forrest) and the Lord Mayor's Charitable Foundation.

Government funding was suggested by several people with the notion that the program could operate as a state Government funded initiative due to the benefit that *'it reduces number of people out of workplace'* and *"we are talking about responses to workplace injuries. When things are not dealt with well there is a much bigger ongoing financial impact to the workplace".*

One respondent raised considerations around the **OHS act which places a duty of care on the organisation** which has caused harm. Insurance-related factors were also raised. Workcover was suggested and one person stated that *"insurers would be interested as it'll reduce costs by reducing number and length of claims"* and one leader drew a comparison with TAC paying towards rescue service and that perhaps this is equivalent to funding a mental health program. Recommendations included incorporating the program as part of mental health plan or private insurance offering due to the preventative nature of this program. One respondent acknowledged uncertainty around the insurance option as they felt there is not an existing culture and prior precedents.

Barriers to program attendance

The **ability to juggle personal, family and caring commitments** were flagged by many respondents as the biggest barrier to attendance. Some highlighted that it would not be practical for everyone to be away from home for four days or even away from the family overnight, especially working mothers with young children and households where the emergency service worker is the main caregiver. This consideration was raised equally be women and men. One study participant shared *"the more remote people are, the less support they have around them".*

Several regional study participants flagged the **challenges faced by regional** emergency service workers. Compounded pressures of the 2020 fires followed by Covid, has resulted in several people in "the orange" already under family pressure, especially in regional locations. One said *"Managing multiple commitments is hard, family etc. People need to free themselves from the shackles to be fully present".*

Annual leave availability is a consideration for volunteers who have paid employment, and potentially for paid emergency service workers if the time must be taken from annual leave entitlements. It was also raised that self-employed volunteers have practical considerations and loss of earnings to consider.

The **practicalities of being released from work for 4 days** was also flagged as a potential major barrier. It was mentioned by many respondents that several agencies have staff shortages and high operational demand, so the agency would need to backfill and accommodate rostering, all of which incurs a financial cost.

Should program participants attend within their regular paid employment hours, one respondent flagged that *"technically they shouldn't do this straight after a shift as it's work-related and 4 days off are for a break from work".* They also raised that it is an OH&S requirement to work 4 days on and 4 days off, so at the end of the 4-day program, the participant would be required to have 4 rostered days off work before returning. This would present further rostering challenges for resource-constrained units.

One DEECA respondent mentioned **agency operational commitments** as another consideration which might impact the ability for some to attend; in their own circumstances; *"they couldn't have it in summer/planned burn time (season Dec - Feb)".*

Location was another factor mentioned by many; it was flagged that the program should not be held at agency facilities. Even though the intent is for the program to be Victoria-based, distance and travel was a concern, including cost-factors in relation to travel. A DEECA respondent felt that the travel is not an issue for employees of that agency, but they would expect to take the work car and expect that cost would be covered by employer. In terms of geographic barriers, some respondents suggested that the program should be centrally located, not Melbourne-based, and many felt the program should be available at a range of locations to promote equity for regional Victorians. One respondent who felt that Melbourne would be too far for individuals at their regional location, also flagged a consideration that participants may prefer not to be around locals only and could *"feel exposed, vulnerable, less willing to share".* Conversely, another respondent stated that *"some people don't like to interact with strangers".*

It was also felt that willingness to attend may be dependent on **the cohort of fellow participants**, however there were mixed feelings around this. Organisational rivalries and judgement were raised as concerns, and a varying level in the trauma and incident intensity dealt with between agencies could impact group cohesion. It was suggested that *"keeping it to one organisation may lower barriers to attendance".* Another felt that it would be *"best if from the same organisation, or from police, ambulance or fire. If broadened to other agencies then the challenges are different".* Another shared *"Police are different beasts and what they deal with is unique to other emergency services and police would be more open amongst other police".* Conversely, one respondent shared that due to confidentiality considerations, they would prefer a mixed group because they are less likely to run into someone who they have worked with before.

Facilitator expertise was raised by several as a key consideration. Respondents felt the program would need to be facilitated by people who understood the pressures of their jobs and that participants must feel rapport and respect the integrity of the facilitators. One FRV leader said they *"would benefit from guidance from a long-standing fire fighter and would not want to sit in a room with a civilian who is non-operational and does not grasp what we do".* A respondent who shared an experience attending a mental health pilot program of two x 1-day sessions said that their facilitators had emergency service experience so were credible and they felt it was good to know in advance who will be in room.

Stigma around discussing mental health or the risk of being labelled as someone with mental health issues was raised by a sizable portion of respondents as a barrier, with select quotes as examples below.

> *Anti-help seeking of males over 40.*

> *Thinking that they will be seen as weak if they talk about this.*

> *Individuals with a 'toughen up' attitude which leads to people resisting support because of fear of judgement"*

> *Concern that psych will think they're mad and there's mistrust around confidentiality."*

> *Stigma re psych illness still exists- what's wrong with you? Suck it up!*

A suggestion to mitigate this risk was to ensure the **program is promoted as focussing on wellbeing** rather than mental health, which has connotations that for people to attend they must have something wrong with them. Confidentiality considerations were raised by almost half of respondents and risk was presented from a professional reputation perspective and concerns that flagging mental health challenges could impact career prospects and medical classification.

Other themes

There were a range of additional thoughts and suggestions shared throughout the interviews to consider in the design and post-implementation follow-up.

Promotion/expectation management:

Several people commented that communication and promotion of the program will need to be carefully considered to garner maximum interest from potential participants.

> *Who will be the champions? Might need voices to talk to/promote this program. These people could help others to see how they can benefit from it.*

> *People like to know what they are in for, what will it look like. They need to be clear about what to expect. Who is going to be there? Will I be psycho-analysed.*

Format:

Some participants made comments about program format or suggested alternatives to the proposed 4-day format to maximise participation:

Would it be possible for some people to go home at night so working mothers with young kids are still able to participate?

Can it be split e.g. two weekends?

Could some be done online?

4 days is a big commitment for someone already struggling. If you have kids and family pressures, no other support at home…. Maybe a two x 2-day program would work well?

Program Content:

Several study participants made comments about what they thought should or shouldn't be included in the program or other ideas about program participant composition

Needs to be different to sitting around talking about feelings. Not formal awkward settings, e.g. animals and support dogs are good ice breaker and make people more willing to interact and be involved. Include other things that are not just focussed on you.

Finish the program with a reflection period.

Language - not too touchy feely as people in these roles often don't like that language.

"Diversity e.g. race, gender, agency culture, sexuality etc. should be taken into account"

Post-Program follow up

Several raised the necessity of follow up and resources to be provided post program to ensure ongoing support.

Review where you are against the continuum / final analysis maybe 3 months / 90 days later to ensure habits have been created….Do they need further support? Then refer them to further support as applicable"

Half to full day to come back together e.g. to ESF office or somewhere appropriate.

They should run a follow up 1/2 day.

There could be a self-assessment before and after the program.

Program sustainability

Some leaders flagged concerns about ongoing viability of the program post pilot in the context of planned sector-wide funding cuts.

Recommendations

The study participants varied in age, gender, location, the service they worked/ volunteered for, and their personal experiences; there is no one size fits all approach to a RWP that will exactly meet the needs of everyone. However, the Right Management recommendations presented below aim to address the common themes emerging from the study interviews.

- The program must be facilitated by professionals with deep sector expertise and a trauma informed approach and include group work plus individual access to facilitators.
- Police and volunteers may need separate programs due to the perceived unique needs of those groups.
- Timing of a volunteer pilot needs to be carefully considered; a weekend may be optimal to minimise time away from paid employment.
- Location of programs need to be mindful of the participant's work and home location.
- The application process will need to be carefully and sensitively managed. Those whose applications are unsuccessful should still be offered an alternative resource/support.
- The referral and prioritisation process requires careful consideration and specialist advice. Self-referral with professional validation is recommended.
- Follow up activities should occur beyond the program to ensure real change is achieved for participants.
- Participants expect to leave the program with a tool kit and strategies to self-manage.
- Pre and post assessment would be useful to demonstrate the tangible benefits of the program and return on investment to justify ongoing resourcing of the program.
- Confidentiality of program participation needs to be carefully considered given concerns from many about potential adverse career impacts if they were perceived as requiring mental health support.
- Participants from the paid workforce should not be expected to take their annual leave to participate in the program.
- Consider accessibility for people with significant caring responsibilities and offer one pilot program specifically for this group to test a different delivery model
- There is a clear lack of appetite from the vast majority of participants to contribute personally to the program costs.

Conclusion

Whilst emergency services work is clearly a rewarding career for paid and volunteer workers, it certainly has its challenges and can take a large toll on the wellbeing of individuals. Study participants were overwhelmingly supportive of the RWP seeing it as bridging an existing gap in early intervention service provision, addressing barriers to early help seeking for people in the orange zone who too often wait until they are severely ill to seek the support they need. The insights from this study will be shared with the codesign group responsible for re-engineering the FRRP to an RWP suited to the Victorian environment to ensure it best meets the needs of Victorian emergency services workers – both paid and volunteer.