Emergency Services Foundation: Residential Wellbeing Program Pilot Final Evaluation Report

May 2025

MELBOURNE

Acknowledgement of Country

Phoenix Australia acknowledges Aboriginal and Torres Strait Islander people as the Traditional Custodians of Country throughout Australia and pays respect to all Elders, past and present. We acknowledge continuing connection of Aboriginal and Torres Strait Islander peoples to land, water and communities—places of age-old ceremonies, of celebration and renewal—and their unique contribution in the life of these lands.

We are committed to fostering an environment in which the relationship between Aboriginal and Torres Strait Islander peoples and their fellow Australians is characterised by a deep mutual respect, leading to positive change in our nation's culture and capacity.

Project acknowledgement

The Emergency Services Foundation (ESF) commissioned Phoenix Australia to undertake an independent evaluation of the ESF Residential Wellbeing Program Pilot. We would like to acknowledge the ESF staff, residential program participants and stakeholders who contributed their time to this project.

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Disclaimer

The views and recommendations stated in this report are solely those of Phoenix Australia and do not represent any endorsement or otherwise by Phoenix Australia of the ESF and/or its programs and services.

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Executive Summary

The Emergency Services Foundation (ESF) piloted a Residential Wellbeing Program (RWP) for emergency service workers in Victoria. The program aimed to support mental health and wellbeing through a 4-day residential retreat. Phoenix Australia evaluated the program to determine its effectiveness and participant experiences.

Forty-eight emergency service workers, representing nine agencies participated in the RWP pilot across six cohorts.

Evaluative surveys were completed at three time points, with high survey response rates.

Time 1
Screening prior to acceptance and attendance on the program

Time 2
4 weeks following attendance

Time 3
6 months following attendance

Key Findings

MENTAL HEALTH IMPROVEMENTS
- Participants showed significant reductions in psychological distress and PTSD symptoms one month after the program, with benefits largely maintained at 6-month follow-up.

BROADER POSITIVE IMPACTS
- Improvements were also seen in functioning, quality of life, and ability to work despite mental health challenges (presenteeism).

HIGH SATISFACTION
- Participants reported very high satisfaction with the program, feeling valued and supported. The location, peer support, and expert facilitation were highlighted as crucial elements.

SKILL APPLICATION
- Many participants reported continued use of skills learned, particularly in communication, mindfulness, and self-care, months after the program.

RIPPLE EFFECTS
- Participants noted positive impacts on their personal relationships and work environments, including improved communication and ability to support others.

COST-BENEFIT POTENTIAL
- Initial analysis suggests the program could be cost-effective compared to potential workers' compensation claim costs, though more comprehensive evaluation is needed.

Limitations of the evaluation

- ! Without a control group to compare the outcomes against, it is difficult to definitively attribute improvements solely to the program.
- ! The 6-month follow-up period limits understanding of longer-term benefits.
- ! The sample included individuals with varying levels of mental health symptoms, which may affect the generalisability of results to any one cohort.

Recommendations

Expand the RWP

Given the positive outcomes, it is recommended that the RWP continue to be implemented and evaluated.

Enhance post-program support

Implement more structured follow-up, including regular check-ins and skill reminders.

Further research

Conduct more rigorous studies with control groups and longer follow-up periods to better understand long-term impacts and cost-effectiveness.

Organisational Integration

Explore how the RWP can fit into broader organisational mental health strategies.

Overall Conclusion

The Residential Wellbeing Program shows promise as an effective intervention for supporting the mental health and wellbeing of emergency service workers. While there is a need for further research with a larger population, **initial results indicate significant benefits for participants and potential cost-effectiveness for organisations and other community and organisational stakeholders such as insurance agents**.

Context

Phoenix Australia was engaged by the Emergency Services Foundation (ESF) to undertake an evaluation of the pilot delivery of their newly developed Residential Wellbeing Program (RWP) for emergency services workers in Victoria. **The purpose of the evaluation was to determine the extent to which the program contributes to positive mental health and wellbeing outcomes for participants, whether any improvements are sustained over time, and to understand participant experiences of the program**. Separate to this, consideration was given to the return on investment of the RWP by ESF's financial partner, Findex.

Background: A brief look at the literature

Mental health among emergency services workers

Emergency service workers, including fire fighters, police officers, paramedics, and Triple Zero employees, face unique mental health challenges due to the nature of their work. These workers may be routinely exposed to traumatic events, life-threatening situations, and high-stress environments, which can have a significant impact on their mental health and well-being. Studies have shown that emergency service workers have higher rates of post-traumatic stress disorder (PTSD), depression, and anxiety compared to the general population (Klimley et al., 2018; Petrie, Joyce, et al., 2018).

The cumulative effect of repeated exposure to traumatic incidents, coupled with long working hours, shift work, and the pressure to make critical decisions under time constraints, can lead to burnout, compassion fatigue, and secondary traumatic stress (the emotional and psychological effects experienced when individuals are indirectly exposed to the trauma of others) among emergency service workers (Carleton, Afifi, Turner, Taillieu, Duranceau, et al., 2018). These mental health issues not only affect the individual's well-being but can also impact job performance, decision-making abilities, and the overall quality of emergency services provided to the public. Moreover, the stigma surrounding mental health in these professions often prevents many workers from seeking help, exacerbating the problem (Haugen et al., 2017).

Australian research has significantly contributed to understanding the mental health challenges faced by emergency service workers. A comprehensive national study by BeyondBlue (2018) on police and emergency services personnel in Australia found that employees and volunteers in this sector have substantially higher rates of psychological distress and probable PTSD compared to the general adult population (Beyond Blue Ltd, 2018). The study reported that 10% of employees were experiencing probable PTSD (more than double the 4% rate reported in the general population), and 21% were experiencing high psychological distress (compared to 13% in the general population). Lifetime diagnoses of mental health conditions were reported by 39% of emergency service employees, substantially higher than the 20% reported for all Australian adults.

The study by BeyondBlue reported that prevalence rates vary across different emergency service sectors, with ambulance personnel demonstrating the highest rates of psychological distress (31%) and probable PTSD (15%). Fire and rescue services reported lower rates of psychological distress (18%) but similar PTSD rates (9%) to other sectors, while police showed intermediate rates of psychological distress (23%) and

PTSD (11%) (Beyond Blue, 2018). These sector-specific variations underscore the need for an awareness of tailoring mental health interventions to subpopulations within the broader sector. Further, a study by Kyron et al. (2021) found that first responders in Australia exhibited higher rates of mental health symptoms compared to other high-risk occupations, including military personnel. The elevated prevalence of suicidal ideation among emergency service workers—with 5% of employees and 8% of volunteers reporting suicidal thoughts in the past year—further highlights the importance of addressing mental health via interventions and support that take into account the nature of the role of these workers (Beyond Blue, 2018). Of significant note, Australian researchers have also highlighted the importance that organisational factors may play in supporting mental health. Lawrence et al. (Lawrence et al., 2018) found that perceived support from supervisors and coworkers was associated with lower levels of psychological distress and PTSD symptoms among emergency service workers.

To address these challenges, initiatives introduced by organisations have ranged from regular mental health screenings, access to confidential counselling services, peer support programs, and training in stress management and resilience-building techniques (Joyce et al., 2018). Research has shown that such interventions can contribute to improving mental health outcomes and reduce the risk of long-term psychological issues among emergency service personnel (Wild et al., 2018).

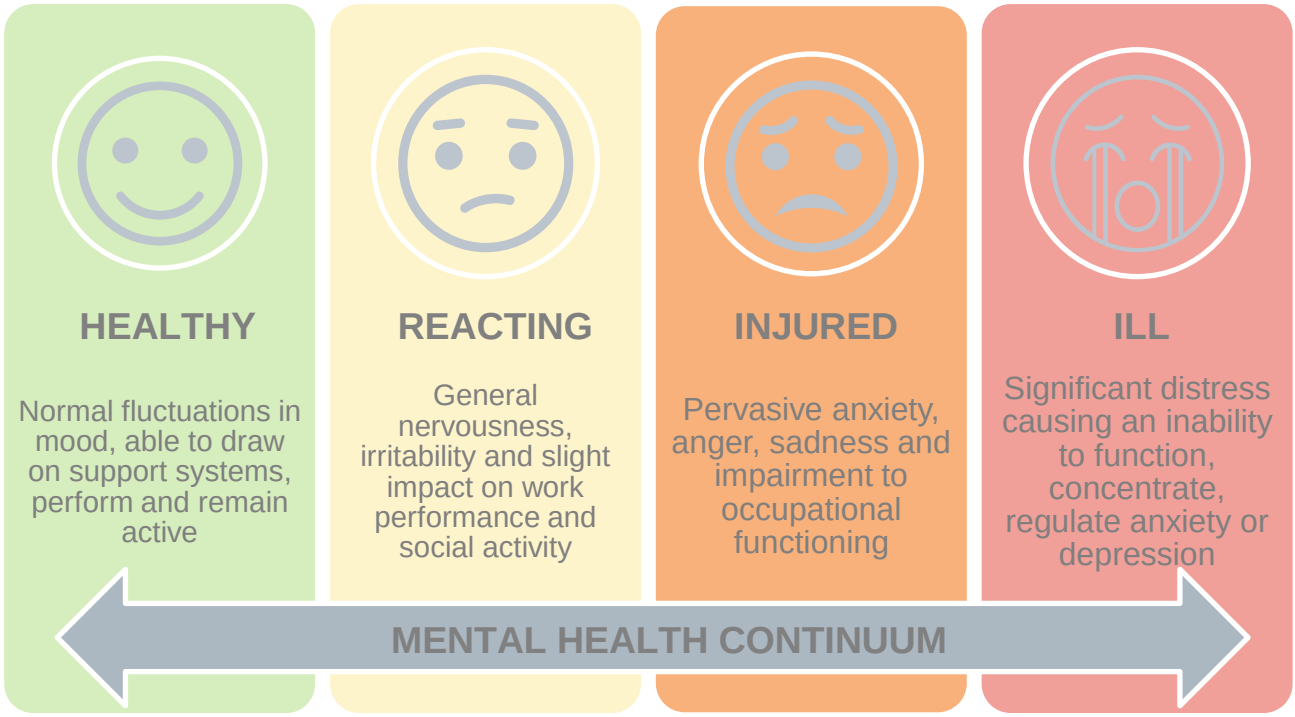
Broad reaching impacts

It is well understood that the impact of mental health problems among emergency service personnel extends far beyond the affected individuals, creating ripple effects that influence colleagues, friends, and family members. Within the workplace, the mental health challenges faced by one team member can significantly affect team dynamics and overall performance. Colleagues may experience increased workload and stress as they compensate for an affected team member's reduced capacity or absence (Milligan-Saville et al., 2017). Moreover, exposure to a colleague's mental health struggles has the potential to lead to secondary traumatic stress or compassion fatigue among co-workers, potentially compromising the mental wellbeing of the entire team (Klimley et al., 2018). This collective impact may result in decreased operational effectiveness, increased absenteeism, and higher turnover rates within emergency service organisations, ultimately affecting the quality of services provided to the community (Petrie, Milligan-Saville, et al., 2018).

The effects of mental health problems in emergency service personnel also permeate their personal lives, significantly impacting family dynamics and social relationships. Spouses and partners of affected individuals have reported elevated levels of psychological distress, relationship dissatisfaction, and caregiver burden (Diehle et al., 2017). Children of emergency service workers with mental health issues may experience adverse developmental outcomes, including increased risk of emotional and behavioural problems (Leen-Feldner et al., 2011). Furthermore, the social withdrawal and irritability often associated with mental health challenges can strain friendships and lead to social isolation, depriving the individual of crucial support networks (Evans et al., 2009). These familial and social impacts can create a cycle of stress and dysfunction that may exacerbate the original mental health problems and hinder recovery. Recognising these far-reaching effects underscores the importance of comprehensive support systems that address not only the mental health of emergency service personnel but also the wellbeing of their families and the resilience of their professional communities (Shakespeare-Finch et al., 2015).

The Mental Health Continuum

The combination of cumulative stress, occupational factors and barriers to help-seeking behaviours can cause fluctuations in the mental health and wellbeing of emergency service workers. The Mental Health Continuum (MHC) is a model that has been used in some instances to describe these changes in mental health, where individuals can move between different states based on various life factors (Chen et al., 2020). The MHC describes mental health as being divided into four different 'zones', each of which have differing levels of distress and coping behaviours that are associated with that state. A brief summary of the MHC and its different zones is presented below.



The green 'healthy' zone is associated with positive functioning, where the individual experiences regular fluctuations in mood that they can cope with effectively, whilst the yellow 'reacting' zone is associated with mild, temporary stress responses such as irritability and disrupted sleep. The orange 'injured' zone reflects more persistent symptoms such as anxiety, withdrawal or reduced sleep, indicating a need for support. The red 'ill' zone represents a shift towards more serious mental health conditions, such as probable PTSD or depression, requiring professional intervention and support. This framework is particularly useful when considering the mental health and wellbeing of populations like emergency service workers, who are likely to shift back and forth along the continuum due the nature of the demands and stressors associated with their role.

Importantly the MHC acknowledges the potential for movement between zones, and highlights that as an individual moves the amount of support required will vary. This speaks to the importance of prevention and early intervention initiatives, to equip individuals with the skills and knowledge to recognise which zone they are in and what supports would be most beneficial.

Prevention and early intervention for supporting good mental health and wellbeing

Prevention and early intervention strategies play an important role in supporting the mental health and wellbeing of emergency service workers. These approaches aim to build resilience, reduce the risk of developing mental health issues, and address problems at their earliest stages. Whist this is still an emerging area within the research literature, there is some evidence to suggest that proactive measures can significantly improve mental health outcomes and reduce the long-term impact of occupational stress on these workers (Petrie, Joyce, et al., 2018). Key preventive strategies identified include resilience training, stress management programs, and the promotion of healthy lifestyle habits. A systematic review by Joyce et al. (Joyce et al., 2018) found that resilience training programs can lead to improvements in resilience, mental health, and performance outcomes among high-risk occupations, including emergency services.

It is important to note that research cited by the World Health Organisation (WHO) suggests that resilience training programs may have limited long-term impact on mental health outcomes (Vanhove et al., 2016). In their comprehensive meta-analysis, Vanhove and colleagues examined 37 studies involving 16,348 participants across various occupational contexts. They found that resilience training programs had a small but significant effect on individual mental health and performance outcomes immediately post-intervention, however, these effects tended to diminish over time. This is likely to be due to a number of factors and may include: the challenge of transferring skills learned in training to real-world, high-stress situations, and the potential lack of organisational support for maintaining and applying skills in the workplace.

These findings align with WHO guidelines that emphasise the need for comprehensive, systemic approaches to mental health support in high-stress occupations, rather than relying solely on individual resilience training (World Health Organization, 2019). The guidelines suggest that effective mental health support should address organisational factors, working conditions, and ongoing support systems, in addition to individual-level interventions. This multi-faceted approach is likely to be more effective in producing sustained improvements in mental health outcomes for emergency service workers.

Early intervention approaches focus on identifying and addressing mental health concerns before they escalate into more severe problems. These strategies can often involve regular mental health check-ups, peer support programs, and easy access to professional mental health services. A study by Milligan-Saville et al. demonstrated that manager mental health training in emergency services led to a significant reduction in work-related sickness absence, highlighting the importance of early recognition and support. Additionally, the implementation of screening tools and brief interventions has shown some promise in identifying at-risk individuals and providing timely support. For example, Carleton and colleagues (2018) suggest that the use of validated screening instruments, such as the Depression Anxiety Stress Scales (DASS-21) or the Post-Traumatic Stress Disorder Checklist (PCL-5), may be able to help identify emergency service workers who may benefit from further assessment or intervention Another important aspect of early intervention is the promotion of help-seeking behaviours. Research has shown that reducing stigma and improving mental health literacy can significantly increase the likelihood of emergency service workers seeking help when needed (Haugen et al., 2017). Further, the integration of mental health professionals within emergency service organisations (sometimes referred to as embedded mental health models) has shown promising potential for providing timely and context-specific support to personnel (Scully, 2011).

Australian research has made significant contributions to understanding effective prevention and early intervention strategies for emergency service workers. The Black Dog Institute, in collaboration with several emergency service organisations, has provided some insights into the mental health challenges faced by firefighters, using self-report data to assess various mental health outcomes (Harvey et al., 2016). Building on this research, the authors developed the 'READY' program (Resilience and Engagement: Addressing Distress in Emergency Services), which focuses on early intervention and prevention strategies. Delivered predominantly online, this program incorporated elements such as mental health literacy, resilience training, and peer support. Whilst the evidence for the READY program is still being built, these kinds of initiatives appear to be able to contribute to improved mental health awareness and support systems within emergency services organisations. Australian researchers have also emphasised the importance of organisational factors in prevention strategies. A study by Petrie et al. (Petrie, Gayed, et al., 2018) found that organisational justice (measured by the employee's perception of fairness within the organisation) and support were associated with lower rates of mental health symptoms among police officers, suggesting that fostering a supportive workplace culture is an important factor in the prevention of mental health issues.

Early intervention approaches within a residential retreat or intensive format.

Over the past decade there has been an increasing interest in mental health and wellbeing interventions delivered in residential retreat formats, particularly in the context of occupational groups such as emergency services workers. The rationale for delivery in a residential format includes preference from participants to receive interventions in a brief, intensive compressed format (Deacon & Abramowitz, 2006) and the opportunity to reduce stigma and create social connection.

The relative recency of the emergence of residential retreat interventions for emergency service workers specifically means there is a limited evidence base, with the majority of studies representing pilots, and feasibility and acceptability evaluations. Rigorous studies, such as randomised controlled trials, are lacking and thus the evidence for the effectiveness of such interventions is still emerging.

Residential retreat programs typically utilise a multi-component approach, including evidence based and adjunctive elements, aimed at improving mental health, wellbeing, and stress reduction (Lowery & Cassidy, 2022). There is a heavy emphasis on the group format, which leverages camaraderie, social support and shared experiences to enhance effectiveness, engagement and reduce stigma. This approach aligns well with the teamwork-orientated nature of emergency services, as well as promotes connection within a unique occupational environment. The intensive format can be beneficial for emergency service workers who have limited time or prefer to receive skills training and psychoeducation in a relatively succinct manner.

The short-term benefits of these programs have been well observed, including marked reductions in mental health symptoms such as depression, anxiety and stress, though the long-term effects may not always be sustained, particularly where regular practice is required. The inclusion of booster sessions following the conclusion of the retreat provide an important opportunity to refresh knowledge and skills and may serve as a reminder for re-engagement in regular skills practice. Due to the intense nature of residential retreats, and the rapid social connection and bonding that occurs, there is the possibility of participants experiencing some feelings of loss and disconnection after finishing the intervention and returning to 'usual life'. Therefore,

follow-up and opportunities for re-connection following conclusion of a retreat-based program should also be considered in planning and design (Murray-Swank et al., 2020).

Trauma-oriented retreats in particular should be considered adjunctive to best practice psychotherapeutic interventions, and there is a need for a stronger evidence base and greater standardisation of programs in this space (Smith-MacDonald, Pike, et al., 2022; Smith-MacDonald, VanderLaan, et al., 2022). While the oversight of programs by mental health professionals and subject matter experts is important for all interventions of this type, it is particularly important for those that are trauma-focused and include participants with probable or diagnosed mental health conditions.

Despite the need for more robust evaluative studies, an examination of the existing evidence suggests that there are particular factors in the design and delivery of such programs that are considered useful. These include:

- A **group setting** (promoting group cohesion, group composition that suits participants needs, closed groups which do not allow new members to join),
- **Manualised and standardised intervention** that follows protocols,
- **Choice** of facilitators and limited intensity/duration of the program,
- **Lived experience facilitators and team leaders,**
- **Comfortable residential setting and location**, sufficiently removed from the occupational area/setting,
- **'Booster' sessions** – extra sessions following the completion of the program that refresh knowledge and skills and encourage re-engagement in regular skills practice.

Programs with these elements are more likely to show potential as a comprehensive intervention method for supporting the mental health and wellbeing of emergency service workers.

The Residential Wellbeing Program

First Responder Resiliency Wellbeing Program

The First Responder Resiliency Program (FRRP) was developed by Duncan Shields and David Kuhl in partnership with the BC Professional Firefighters Association, the BC Police Association, and Blueprint at the University of British Columbia *(BC First Responders' Mental Health,* 2025*)*. The program is a small-group, peer-based, relationship-centred 4-day residential retreat. It aims to provide a concentrated period of support while minimising the disruption to participants' professional and personal lives and is designed to address symptoms associated with routine exposure to occupational stressors, injury-related leave, and domestic impacts of service (Blueprint, n.d.). The British Columbia FRRP (BCFRRP) is intended to provide 34 hours of group-based counselling, peer support, and skills development, aiming to strengthen the resilience of participants at any phase of life or any stage of their career.

According to the website (*BC Fire Fighter Resiliency Program - Program Info* the objectives of the BCFRRP are to:

- Support first responders to understand how operational stress affects their body, mind, behaviour and relationships.

- Provide a structured, peer-supported space to process personal experiences.
- Build communication and peer support skills to manage stress and enhance resilience.
- Help participants address unresolved experiences effecting daily life.
- Strengthen personal relationships, including family and partners.
- Complement existing services by connecting participants to additional support where needed.

While there is currently no peer-reviewed literature reporting on the effectiveness of the BCFRRP, an independent evaluation of the program conducted by the University of Canberra, found that the program was associated with improved well-being in emergency service workers, reduced trauma-related stress, depression and anxiety, alongside enhanced quality of life, social support and resilience (Lukersmith et al., 2024). Broader program information from Blueprint reports clinically and statistically significant improvements in depression, trauma symptoms, social and occupational functioning, and overall well-being among participants, with these benefits sustained at six-months after completing the program (BC Fire Fighter Resiliency Program - Program Info).

Victorian RWP Program Pilot

Based on the encouraging findings from the University of Canberra evaluation, and broader emerging evidence for the utility of programs of this type in supporting the mental health and wellbeing of emergency services populations, a pilot of the program was undertaken in Victoria, Australia. The lead Australian program facilitator undertook a train the trainer program in Canada, working with the BCFRRP creators at Blueprint. Following this, ESF signed an agreement with Blueprint to use the BCFRRP Intellectual Property for the purposes of piloting the program. As such, all program design, delivery and activity components were based on the BCFRRP, however the Victorian RWP included the addition of each participant having a nominated support person. This was decided on the basis of emergent Australian and international research findings regarding the important role of families in supporting mental health and wellbeing, and recovery among veteran and first responder populations (Diehle et al., 2017; Shakespeare-Finch et al., 2015) alongside the work ESF have undertaken in the families space.

The Victorian RWP offered an intensive four days of skill development, delivered in a residential setting across four days and three nights, for Victorian Emergency Services workers looking to enhance their resilience and strengthen their capacity to manage stress borne from organisational, operational, and familial situations.

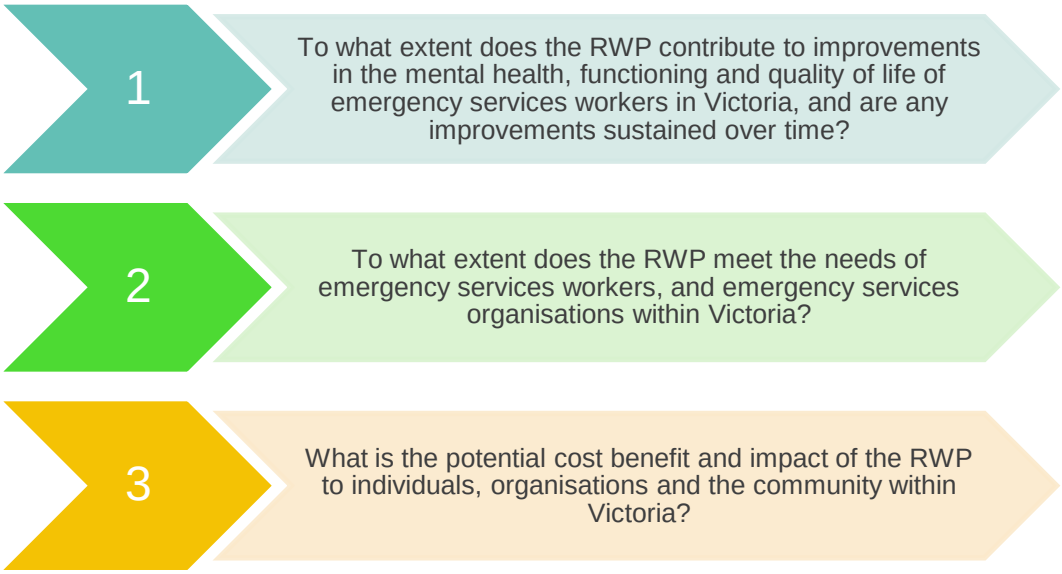
The stated purpose of the RWP for Victorian emergency service workers was to:

- Assist serving emergency workers to understand the mechanisms and effects of operational stress on the body, the brain, on behaviour and on relationships.
- Provide opportunity to discuss the impact of personal emergency response experiences with peers in a systemic and professionally facilitated environment.
- Equip participants with skills for self-regulation, effective communication, and planning strategies to maintain their resilience while facing ongoing operational challenges.
- Help minimise progression to serious mental injury and WorkCover claims.
- Demonstrate through evaluation the benefit of such an early intervention initiative for participants, families and organisations.

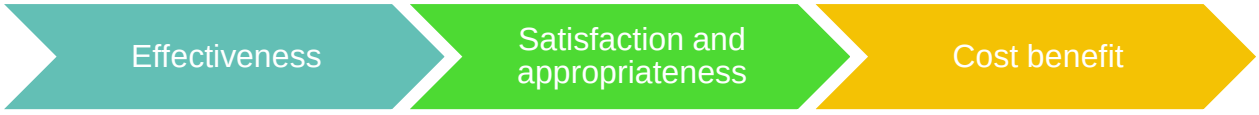
Evaluation aim and objectives

The evaluation aimed to determine the extent to which the Victorian RWP Pilot has contributed to positive mental health and wellbeing outcomes for participants, whether any improvements have been sustained over time, and to understand participant experiences of the program. The evaluation activity also contributed to quality assurance and monitoring processes and informed iterative program improvements where indicated.

Key evaluation questions and domains of assessment



The core domains, linked to the evaluation questions, for assessment in this evaluation were:



Methodology

The methodological approach taken stemmed from contemporary evaluation theory, particularly drawing upon the principles of developmental evaluation (Patton, 2010) and formative assessment (Scriven, 1967). Importantly, this approach to the evaluation facilitated a dynamic, iterative process of program refinement throughout the pilot phase. By systematically integrating participant feedback into the program's evolution, the evaluation team were able to feed back "real-time learning" to the RWP stakeholders to facilitate improvements (Gamble, 2008). This methodology aligns with Preskill and Beer's (2012) (Preskill & Beer, 2012)concept of evaluative thinking, which emphasises the importance of continuous inquiry and evidence-based decision-making throughout program development. The iterative feedback loops established during the evaluation process should serve to not only enhanced the program's efficacy but also its ecological validity.

Return on investment

Findex were commissioned separately by ESF to undertake a brief return on investment review, to supplement other evaluation activities. The full Findex report is contained in Appendix B. A verbatim summary of the analysis methodology, results and conclusions is included at the end of the results section.

Recruitment and data collection

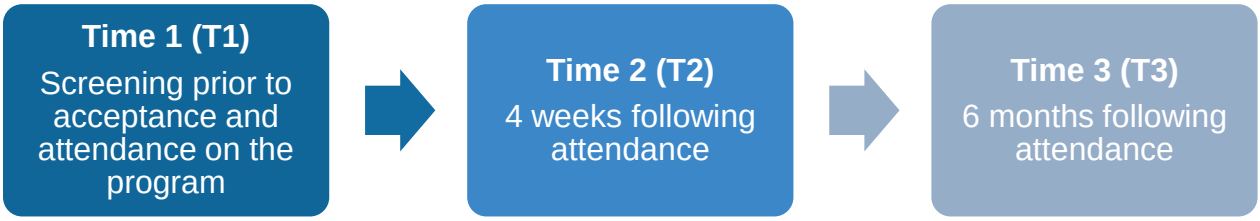
During the first quarter of 2024 (January – March), the RWP pilot was advertised on ESF social media channels, directing individuals to the ESF website for more information. Individuals who worked or volunteered within the emergency services sector in Victoria were eligible to apply to participate in the program. Participant recruitment, screening, review and follow up processes are illustrated below.

Interested individuals registered their interest via the pilot program webpage and completed consent and a screening questionnaire assessing their current mental health and wellbeing.

Survey results underwent clinician review, and clinical facilitators interviewed potential participants to confirm suitability for the group-based program activities and clinical eligibility to participate in the program. **The**

program was targeted towards individuals who were in the yellow to orange zone of the mental health continuum (low to emerging or subthreshold mental health symptoms). All interested individuals who had symptom screening scores in the red zone (indicating probable mental disorder) underwent further clinician review, with eligibility to participate decided on a case-by-case basis dependent on their level of mental health complexity and likelihood of benefiting from the program. Ineligible participants, or those who were eligible but unable to attend a scheduled program were provided alternative referral pathways for support.

All individuals who participated in the RWP were invited to complete survey measures at three time points:



This data was collected and managed by ESF as part of their quality assurance and monitoring process, and for the purpose of clinical assessment and review of participants. Data for all participants was de-identified before being provided to Phoenix Australia for the purpose of undertaking the evaluation.

One month following conclusion of the RWP, participants attended a post-program clinical review and check-in session with other participants from their cohort, their support people, and the clinical facilitators of the program. They were also invited to attend a focus group via zoom at the end of the post program review session. This focus group was facilitated by the Phoenix Australia research team and involved a guided discussion of participant experiences engaging in the RWP.

A total of six cohorts of eight participants attended the program run across four days on the Mornington Peninsula between April and October 2024. Each group was facilitated by two mental health professionals (a psychologist and a mental health counsellor) familiar with the emergency services environment.

Iterative program refinement

While the RWP followed the format of the parent program (BCFRRP), as this represented the first pilot of the program within the Australian context, it was recognised there may be iterative improvements to the program identified throughout implementation. All improvements were informed by facilitator reflections based on running the program as well as interim evaluation findings regarding participant experiences on and feedback about the program that were fed back to ESF during the evaluation period.

None of the core program activities were modified, however a number of changes were made that were intended to support delivery of and engagement with core program content, and in response to participant feedback. Each modification, including when it was introduced, is summarised below.

Timeframe	Refinement
Prior to commencement of pilot	➢ Program facilitators reviewed the basic education material around the topic of 'communication' which was to be presented on the first day during the psychoeducation component. They identified an opportunity to supplement this information with further detail about communication types and contexts (operational communication vs emotional communication). The facilitators felt that this enabled participants to gain a deeper understanding of communication within different contexts and supported understanding and application.
Following first program cohort	➢ Participant feedback and facilitator observations indicated that some participants weren't equipped with the emotion vocabulary needed to undertake the core storytelling exercise. In response, the facilitators introduced an additional education module covering emotion vocabulary, that would front load participants with information and skills to support the activity. This was included in all subsequent programs. ➢ Feedback from participants and support people indicated that there was a preference for consistency in language, referring to the 'support person' rather than 'significant other' as had been used originally. ➢ An optional massage was introduced at the end of the storytelling exercise in acknowledgement of the intensity of that activity, and feedback from participants indicating that an opportunity to 'wind down' after would be helpful. ➢ Participant feedback highlighted that the timing of the program meant that many would finish the program on a Thursday and have to go straight back to work on the Friday. This was challenging and it was recommended that participants be advised that they should consider taking the Friday off to allow sufficient time to ease back into regular life on their return from the RWP. Following the 5th program, based on ongoing participant feedback, ESF explicitly requested that all participants take the Friday after the program off, and liaised with organisations to support this.
Following second program cohort	➢ Facilitators identified that some participants were finding a particular element of the storytelling exercise challenging. When they were asked to reflect on the stories of others and invited to share a piece of their own story that overlapped, some participants found this difficult to conceptualise. To aid this, the facilitators introduced a visual aid in the form of a Venn diagram, to provide a concrete illustration of what the 'shared element' of each story might look like. ➢ Participant and support person feedback revealed that many support people felt they had insufficient information about what participants would be experiencing on the program, and what to expect when they returned home. In response, a video and additional email communication with detail about what to expect was provided to all support people. ➢ Facilitators identified that some participants were finding the end-of-program goal setting activity challenging. For subsequent programs, a framework for self-care was introduced prior to the goal setting activity, which provided participants with a tangible framework for considering what goals might be most relevant for them moving forward.

Following fourth program cohort	➢ Based on feedback from participants regarding check-ins and follow-up communication, ESF introduced weekly emails between the end of program and the 4-week follow-up, which provided relevant information, resources and links related to the skills and activities from the program. Participants were also given greater encouragement to contact facilitators during the 4 weeks immediately post-program.

Measures

Effectiveness, satisfaction and appropriateness

A range of data sources and measures were utilised to describe the participant cohorts, and evaluate the short- and medium-term effectiveness, appropriateness, and participant satisfaction with the RWP. These included administrative data from ESF, self-report surveys and written qualitative feedback, focus groups with participants and support people, and observations from program facilitators. Key measures and data sources relating to each evaluation domain are summarised below, with further detail in Appendix A.

Evaluation domain	Data source	Timing	Measures
Effectiveness	ESF administrative data	End of pilot	➢ Gender ➢ Age ➢ Employment type (employed, volunteer) ➢ Organisation ➢ Current mental health diagnosis pre-program ➢ Receiving mental health treatment pre-program
	Participant self-report survey	Pre-program, one-month post-program, 6-months post-program	➢ PCL-5: Posttraumatic stress disorder checklist for DSM-5 ➢ K10: Kessler Psychological Distress Scale ➢ Functional impairment: Extent to which psychological distress has interfered in the domains of home management, work, relationships and social life ➢ Schuster Social Support Scale (adapted): Perceived social support from family, friends, colleagues and supervisor ➢ WHOQOL-Brief: World Health Organisation Quality of Life – Brief form ➢ Stanford Presenteeism Scale: Occupation presenteeism due to mental health over a 4-week period

	Participant and support person focus groups	One-month post-program	Participant ➢ Thoughts on the program ➢ Skills application Support person ➢ Observable impacts ➢ Observable changes
	Participant written responses	Six-months post program	Participant ➢ Skills application
Satisfaction and appropriateness	Participant and support person focus groups	One-month post-program	Participant ➢ Sharing the experience ➢ Program feedback ➢ Suggested changes ➢ Ongoing connection with the group ➢ Advocacy and recommendations Support person ➢ General feedback and thoughts
	Participant written responses	Six-months post program	➢ Suggestions for post-program ➢ Any other feedback or thoughts
	Facilitator feedback and observations	End of pilot	➢ Preparation for the cohort ➢ Challenges in delivery ➢ Engagement of participants ➢ Specific benefits ➢ Stand out components ➢ Suggested improvements

Evaluation findings

The following section describes the pilot participant sample characteristics and response rates, then presents the outcome of data collection activities according to each evaluation domain. Where appropriate, data from a range of sources were triangulated to generate synthesised findings for each domain.

Participant characteristics and response rates

Survey response rates

Table 1 below provides a summary of the number of survey completions for people who did the RWP program. Eight participants did not complete the post-program survey, and 8 participants did not complete the follow-up survey at 6-months, leaving a total of 36 participants (75.0%) who completed all three survey timepoints.

Table 1: Survey completion rates.

Survey time point	n	
Completed Pre-program survey (T1)	48	100.0%
Completed Post-program survey (T2)	40	83.3%
Completed Follow-up Survey (T3)	40	83.3%
T1 and T2 responses	40	83.3%
T1, T2 and T3 responses	36	75.0%

A total of n=65 individuals expressed interest in participating in the RWP, with n=48 of these individuals going on to attend one of the pilot programs. Of those who attended the program, 100% (n=48) completed a pre-program survey, 83.3% (n=40) completed a post-program survey, and 83.3% (n=40) completed a follow-up survey. A total of 75% (n=36) had matched data across all three survey timepoints and were included in substantive analyses.

Participant characteristics

Table 2 describes the demographic characteristics of all participants and the matched sample who completed all 3 survey timepoints. Just over half the participants were female (56.3%), and slightly more female participants had matched data across all timepoints. The mean age of the sample was 48.7 years. Two thirds of participants were employed at the time of attending the RWP program (66%) and were either employed or volunteered at a broad range of emergency services organisations including Ambulance Victoria, Country Fire Authority, DEECA Forest Fire Management, Fire Rescue Victoria, Life Saving Victoria, Red Cross, State Emergency Service, Triple Zero and Victoria Police. Just under half of participants reported having a current mental health diagnosis and/or receiving current mental health treatment prior to commencing the program[1].

Data regarding current mental health diagnosis and current mental health treatment was documented in participant clinical notes held by ESF and provided (deidentified) as part of the administrative data to Phoenix Australia.

Table 2: Demographic characteristics of the survey respondents.

	All participants (n=48)		Survey responder at all 3 time points (n=36)	
	n	**%**	**n**	**%**
Gender				
Male	21	43.8	13	36.1
Female	27	56.3	23	63.9
Age (M, SD)	48.7	10.2	48.3	10.6
Employment type				

[1] **IMPORTANT NOTE**: The program was originally intended for individuals with early to subthreshold mental health symptoms, rather than those with higher symptoms and probable mental disorder. However, a substantial proportion of individuals who expressed interest in participating screened as having probable mental disorder, and following clinician review were accepted into the pilot. This is reflected in the administrative data showing the number of participants with existing mental health diagnoses and/or receiving mental health treatment at pre-program.

	All participants (n=48)		Survey responder at all 3 time points (n=36)	
Employed	37	77.1	28	77.8
Volunteer	11	22.9	8	22.2
Current mental health diagnosis*				
No	25	53.2	18	51.4
Yes	22	46.8	17	48.6
Current mental health treatment*				
No	27	57.4	21	60.0
Yes	20	42.6	14	40.0

**Note*: not all participants had data available on current mental health diagnosis or current mental health treatment

Qualitative data

Focus groups

- Focus groups comprising participants and their support people (where available), were held for each cohort one-month post-program. Where required, additional focus groups were held within one week for any participants who were unable to attend the scheduled focus group session. Data was extracted for a total of 9 focus groups, including n=37 participants and n=26 support people.

Written responses

- A total of n=40 participants provided written feedback at 6 months post-program.

Facilitator feedback

- Feedback from program facilitators (n=3) was captured ad hoc throughout the data collection period, through written and verbal communications, and through a brief semi-structured interview at the conclusion of the pilot period.

Program effectiveness

Program effectiveness was assessed utilising self-report measures of mental health, functioning, social support, quality of life and presenteeism, administrative data where relevant, qualitative focus groups and written responses from participants and significant others examining the experience and perceptions of the program and its impacts.

Outcomes are presented for the participant cohort with matched data at all three timepoints (T1 - pre-program, T2 - post-program and T3 - 6-month follow-up). Additional supplementary analyses looking at outcomes for participants who completed T1 and T2 (n=40) and T1 and T3 (n=40) showed no significant difference in patterns of outcomes, therefore only results for participants with complete data across all time points are presented.

Due to the heterogenous nature of mental health symptom status at pre-program among the participant cohort, and the inclusion of individuals who had probable or diagnosed mental disorder in the pilot, further supplementary descriptive analyses comparing outcomes among the following participant subgroups were performed, and are described in text where relevant:

- Existing mental health diagnosis at T1
- Engaged in mental health treatment at T1

Mental health

To examine change in mental health over time in program participants, both mean scores on measures of psychological distress and PTSD, and probable disorder categories on each measure were examined.

Change in mental health symptoms over time

Table 3 presents the mean change in symptoms of psychological distress and PTSD over time.

Symptoms of psychological distress decreased significantly between T1 and T2 and this decrease was maintained at T3. Similarly, symptoms of PTSD significantly decreased between T1 and T2, and this decrease was maintained at T3.

Supplementary analyses examining outcomes for participant subgroups with a mental health diagnosis or receiving mental health treatment at pre-program showed that both subgroups recorded higher levels of symptoms at T1 (as expected). These groups experienced similar sized reductions as those without mental health diagnosis or treatment in terms of symptoms of psychological distress and PTSD symptoms between T1 and T2, with these reductions maintained at T3 (noting that their mean scores were always higher).

Table 3: Mean (SD) K10 scores at pre-program, post-program, and follow-up (n=36).

	Pre-program (T1)	Post-program (T2)	Follow-up (T3)	T1 vs. T2	T1 vs. T3	T2 vs. T3
	M (SD)	M (SD)	M (SD)	d (95% CI)	d (95% CI)	d (95% CI)
Psychological distress (K10)	22.4 (7.9)	14.8 (4.7)	15.9 (6.2)	-1.15 (-1.57, -0.72)***	-0.91 (-1.29, -0.51)***	0.27 (-0.06, 0.61)
PTSD symptoms (PCL-5)	28.2 (17.8)	12.2 (13.0)	14.4 (16.0)	-0.99 (-1.39, -0.59)***	-0.75 (-1.12, -0.38)***	0.18 (-0.15, 0.51)

Change in psychological distress symptom severity categories over time

Table 4 and Figure 1 present the proportion of participants with psychological distress (K10) scores indicating no mental disorder, subthreshold mental disorder and probable mental disorder at each measurement timepoint.

At pre-program just under 50% of participants had K10 scores indicative of probable mental disorder, with 25% scoring in the subthreshold disorder range, and 25% with scores indicating no mental disorder. At the post-program measurement, the proportion of participants with scores in the

probable disorder range had reduced to under 10%, while the proportion with scores indicating no mental disorder had tripled to just under 75%.

Table 4: Frequencies and proportions of participants with scores in the K10 groupings at pre-training, post-training, and follow-up (n=36).

	Pre-program (T1)		Post-program (T2)		Follow-up (T3)	
	n	**%**	**n**	**%**	**n**	**%**
No mental disorder (10-16)	12	33.3	28	77.8	24	66.7
Subthreshold mental disorder (17-24)	8	22.2	5	13.9	7	19.4
Probable mental disorder (25+)	16	44.4	3	8.3	5	13.9

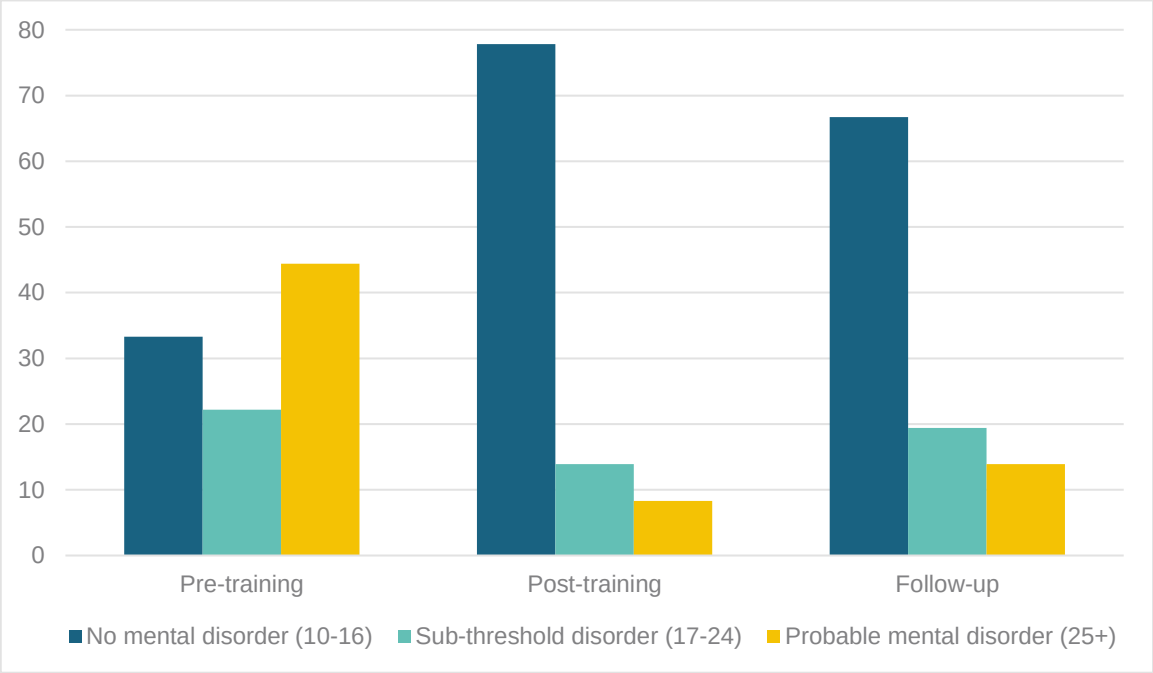


Figure 1. Proportion of participants with scores in the K10 groupings at pre-training, post-training, and follow-up (n=31).

Within subject symptom trajectories

Figure 2 shows the disorder classification trajectories of participants from pre-program to post-program and at 6-month follow-up. Of those with scores indicating no disorder at pre-program (n=12), the vast majority maintained this (87.5%), with just one participant reporting an increase in symptoms to the subthreshold level at post-program. This change was maintained through to follow-up.

Among the group reporting symptoms of subthreshold disorder at pre-program (n=8), the majority had reductions in symptoms to no mental disorder levels at post-program and follow-up. Among participants who started the program with probable disorder level symptoms (n=16), 60% reported symptom reductions to no disorder levels at post-program. Importantly, by the 6-month follow-up time point just one in four maintained their probable disorder status.

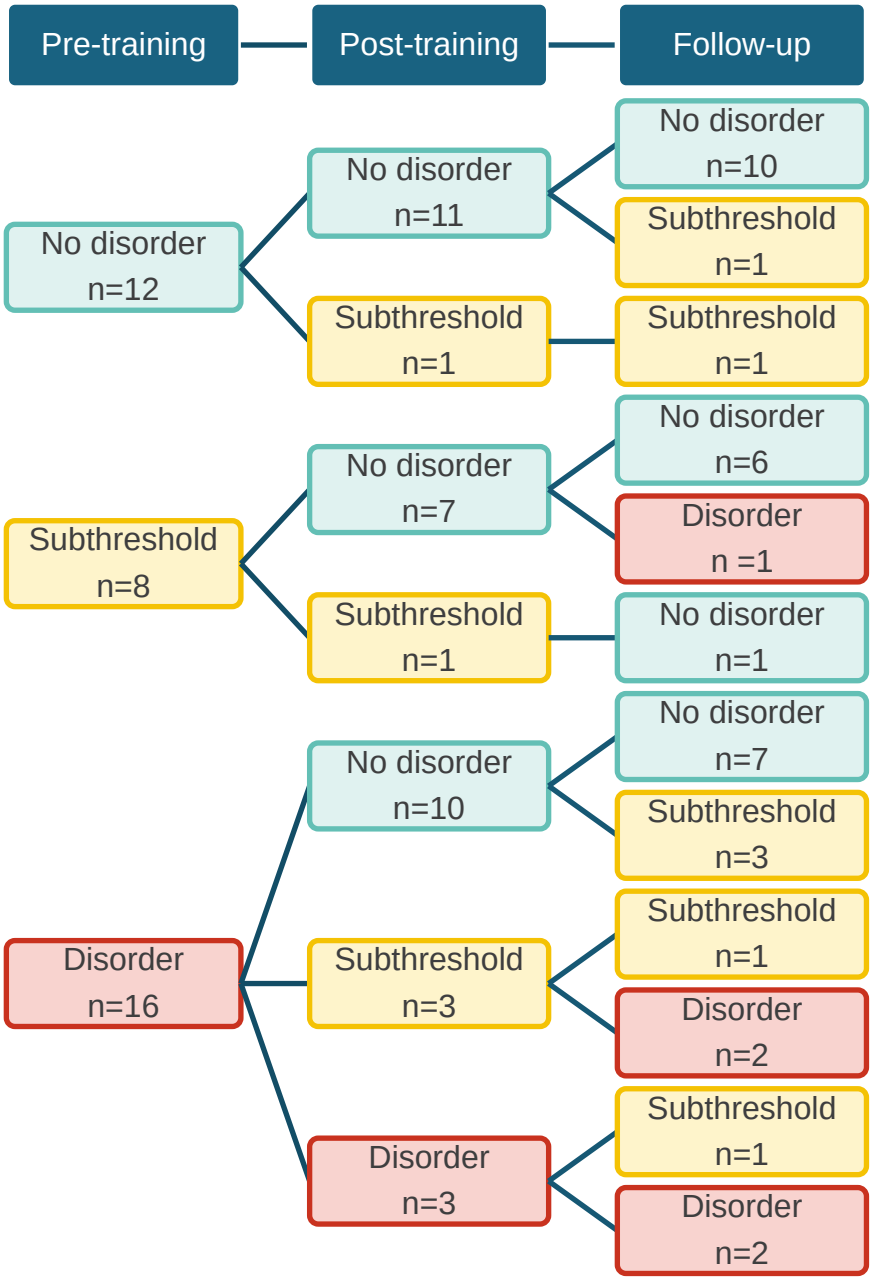


Figure 2: Mental disorder trajectory on the K10 at pre-program, post-program, and follow-up (n=36).

Change in probable PTSD classification over time

Table 5 and Figure 3 shows the proportion of participants with probable PTSD (as measured by the PCL-5) at pre-program, post-program and at 6-months follow-up.

The proportion of participants with scores indicating probable PTSD at pre-program (36.1%) reduced to 8.3% at post program, with a small increase to 13.9% at follow-up.

Table 5: Frequencies and proportions of participants with probable PTSD (scores 33+) on the PCL-5 at pre-program, post-program, and follow-up (n=36).

	Pre-program (T1)		Post-program (T2)		Follow-up (T3)	
	n	%	n	%	n	%
No PTSD (0-32)	23	63.9	33	91.7	31	86.1
Probable PTSD (33-80)	13	36.1	3	8.3	5	13.9

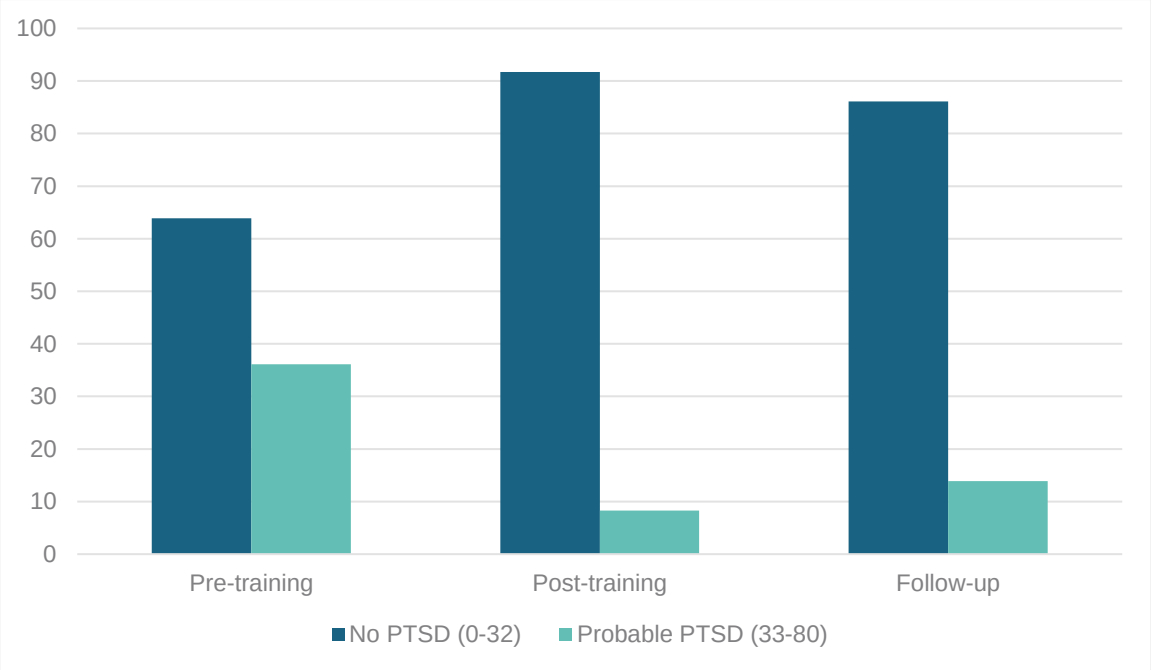


Figure 3: Proportion of participants with probable PTSD (scores 33+) on the PCL-5 at pre-program, post-program, and follow-up (n=36).

Within subjects PTSD trajectories

Figure 4 shows the disorder classification trajectories of participants from pre-program to post-program and at 6-month follow-up. Of those with scores indicating no PTSD at pre-program, all participants maintained this at the time of program completion (100%) and the vast majority maintained this up until the 6-month follow-up (94.7%), with one participant scoring in the PCL range indicating probable PTSD.

Among the group reporting probable PTSD symptoms at pre-program, the majority had reductions in symptoms to the level of no probable PTSD at post-program and follow-up (75%). Of participants indicating probable PTSD, three participants had symptoms that remained above the PCL-5 threshold for PTSD at post-program and follow-up.

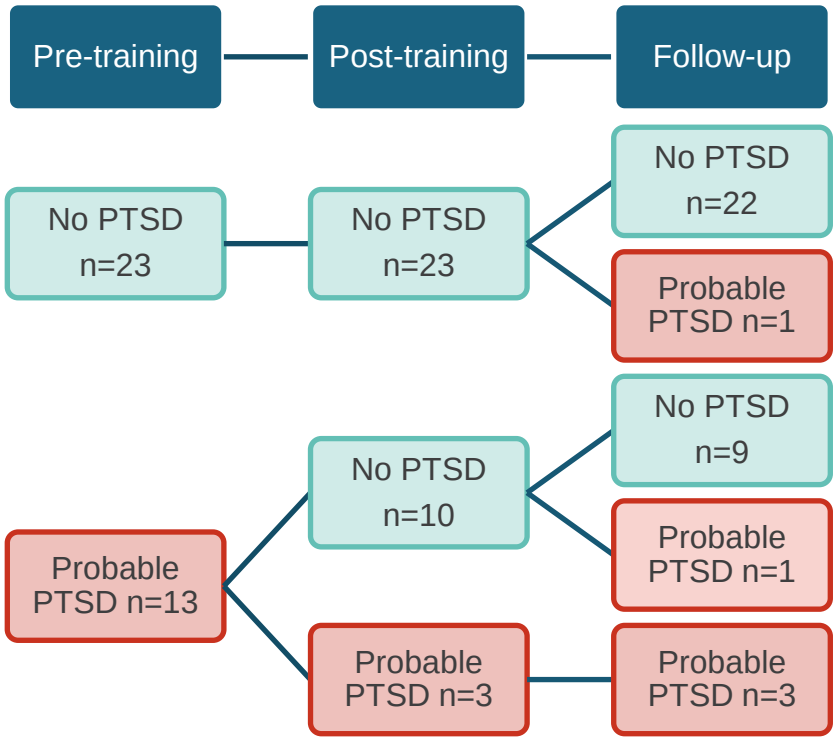


Figure 4: Probable PTSD (scores 33+) trajectory on the PCL-5 at pre-program, post-program, and follow-up (n=36).

Social support

Table 6 shows self-reported perceived social support from family, friends, colleagues and supervisors at pre-program, post-program and follow-up. Overall, perceived social support was generally high across all support domains at pre-program, and this was maintained over time. Interestingly, there was a small but significant additional increase in perceived social support from friends at the 6-month follow-up time point.

Supplementary analyses showed that participants who had a current mental disorder at pre-program, reported slightly lower social support across all domains at all timepoints compared to those without a current disorder, however showed the same pattern and magnitude of improvement over time.

Table 6: Levels of social support as measured by the Schuster Social Support Scale at pre-program, post-program and follow-up (n=36).

	Pre-program (T1)	Post-program (T2)	Follow-up (T3)	T1 vs. T2	T1 vs. T3	T2 vs. T3
	M (SD)	M (SD)	M (SD)	d (95% CI)	d (95% CI)	d (95% CI)
Family	9.8 (3)	10.2 (3.2)	10.5 (3.4)	0.22 (-0.12, 0.55)	0.22 (-0.12, 0.54)	0.10 (-0.23, 0.42)
Friends	11.5 (2.4)	12 (2.7)	12.4 (2.4)	0.30 (-0.05, 0.63)	0.41 (0.07, 0.76)*	0.21 (-0.12, 0.54)
Colleagues	9.7 (3.2)	10.1 (2.6)	10 (2.7)	0.11 (-0.22, 0.45)	0.08 (-0.25, 0.41)	-0.01 (-0.35, 0.33)
Leadership/supervisor	9.9 (3.4)	9.8 (3.6)	10.2 (3.5)	0.03 (-0.31, 0.36)	0.13 (-0.21, 0.47)	0.07 (-0.26, 0.41)

Functioning

Table 7 below presents the level of total functional impairment, and impairment in the domains of home management, work, relationships and social, reported at each time point. Overall, total functional impairment reduced significantly over time, and this was the case across each of the individual domains. Reductions were generally maintained at follow-up, though not to the same degree as post-program levels.

Supplementary analyses showed that participants with a current mental disorder or who were engaged in mental health treatment at pre-program had slightly greater functional impairment across all domains and at all timepoints, however the pattern and magnitude of improvements were similar to other participants.

Table 7: Degree of functional impairment as measured by an adapted version of the Sheehan Disability Scale at pre-program, post-program and follow-up (n=36).

	Pre-program (T1)	Post-program (T2)	Follow-up (T3)	T1 vs. T2	T1 vs. T3	T2 vs. T3
	M (SD)	M (SD)	M (SD)	d (95% CI)	d (95% CI)	d (95% CI)
Total	10.6 (4)	6.1 (2.7)	7.8 (4.1)	-1.34 (-1.78, -0.88)***	-0.79 (-1.16, -0.41)***	0.60 (0.24, 0.95)**
Home management	2.7 (1.1)	1.5 (0.7)	2 (1.1)	-1.22 (-1.65, -0.78)***	-0.61 (-0.96, -0.25)***	0.52 (0.16, 0.86)**
Work	2.7 (1.3)	1.6 (1)	2.1 (1.4)	-0.88 (-1.26, -0.49)***	-0.47 (-0.81, -0.12)**	0.50 (0.15, 0.85)**
Relationships	2.5 (1.1)	1.5 (0.7)	1.8 (0.8)	-0.89 (-1.27, -0.50)***	-0.86 (-1.24, -0.47)***	0.32 (-0.02, 0.65)
Social	2.7 (1)	1.6 (0.9)	2 (1.1)	-1.18 (-1.61, -0.75)***	-0.81 (-1.19, -0.43)***	0.50 (0.15, 0.84)**

Quality of life

Table 8 shows the change in reported quality of life across all timepoints. There was a significant increase in self-reported quality of life over time, across all domains, with moderate to large effect sizes. The greatest improvements were seen in psychological health and physical health. There were significant improvements in overall quality of life and across different domains between pre and post-program and these improvements were maintained at the 6-month follow-up.

Supplementary analyses showed that participants who had a current mental condition at pre-program had lower overall quality of life, including across all domains, at all timepoints, however the pattern and magnitude of improvement was consistent with other participants.

Table 8: Quality of life as measured by the WHOQOL-BREF at pre-program, post-program and follow-up (n=36).

	Pre-program (T1)	Post-program (T2)	Follow-up (T3)	T1 vs. T2	T1 vs. T3	T2 vs. T3
	M (SD)	M (SD)	M (SD)	d (95% CI)	d (95% CI)	d (95% CI)
All items	13.1 (1.7)	14.6 (1.7)	15.4 (2.5)	1.00 (0.59, 1.40)***	1.11 (0.69, 1.52)***	0.46 (0.11, 0.80)**
Perception of overall quality of life and health	13.2 (3.1)	15.3 (3.1)	15.5 (3.2)	0.75 (0.38, 1.12)***	0.71 (0.34, 1.07)***	0.07 (-0.26, 0.39)
Physical health	11.3 (1.5)	13.1 (1.6)	15.3 (2.6)	1.03 (0.62, 1.43)***	1.58 (1.08, 2.07)***	0.94 (0.54, 1.33)***
Psychological	12.3 (1.9)	13.4 (2.1)	14.6 (3.3)	0.79 (0.41, 1.16)***	0.93 (0.54, 1.32)***	0.50 (0.15, 0.85)**
Social relationships	12.8 (3.2)	14.6 (3.1)	14.5 (3.8)	0.62 (0.26, 0.97)***	0.48 (0.13, 0.82)**	-0.02 (-0.35, 0.31)
Environment	15.3 (2.3)	16.6 (2.1)	16.5 (2.3)	0.73 (0.35, 1.09)***	0.54 (0.19, 0.89)**	-0.06 (-0.39, 0.26)

Presenteeism

Table 9 below presents the mean change in presenteeism and the perceived ability to perform work, despite mental health challenges. Presenteeism significantly increased between pre and post-program, and this improvement was sustained at 6-month follow-up, indicating a greater ability for participants to finish tasks at work, handle stress etc., despite continuing to have some degree of mental health struggle.

Supplementary analyses showed that participants who had a current mental condition at pre-program, or were receiving treatment for their mental health at pre-program had lower presenteeism at all timepoints, however the pattern and magnitude of improvement was consistent with other participants.

Table 9: Presenteeism as measured by the Standford Presenteeism Scale at pre-program, post-program and follow-up (n=36).

	Pre-program (T1)	Post-program (T2)	Follow-up (T3)	T1 vs. T2	T1 vs. T3	T2 vs. T3
	M (SD)	M (SD)	M (SD)	d (95% CI)	d (95% CI)	d (95% CI)
Presenteeism	19.2 (5.1)	23.5 (5)	23.4 (6.6)	0.88 (0.49, 1.26)***	0.61 (0.25, 0.96)***	0.00 (-0.33, 0.32)

Perceptions of impact and effectiveness

Perceptions of program impact and effectiveness were assessed through focus groups with participants and support people one month post program, and written feedback from participants 6-months post program.

Program impact

When participants were asked about their experience on the program, the majority reported that it was **impactful and transformational**, and many spoke of the **ongoing positive impacts** since completing the program.

> ***"Found it enlightening, walked away with a lot less baggage than I had when I walked in"***
>
> ***"Felt the benefits of it since I've been home, ongoing process, not a solution to everything but has given me the tools to get to if I waver off the path"***
>
> ***"It gave me the opportunity and skills to continue my mental health journey and continue my growth"***
>
> ***"Given me the knowledge and the tools to process the stuff I have gone through."***

Support people also reflected on the transformational impact of the program, "***[they've] fallen in love with life again***", and the way in which **skills learnt on the program had flow on effects** in their personal relationships and home life, "***there's been a lot of growth within [them] and within our relationship as a result***". Many support people spoke of greater "***closeness and connection***" and improved communication, "***[a] new level of communication that we have with listening and connecting***".

Effectiveness and impact of program activities and components

Participant responses highlighted **two key areas of impact** relating to the activities and components of the RWP: tools and skill acquisition, and emotional processing and reflection.

Participants found the tools and skills taught during the program to be highly beneficial overall, and the broad scope of tools covered meant that participants could find those that worked best for them. The core element of the program regarding emotional processing and reflection on personal experiences was considered by many to be a defining feature of the program and had a meaningful impact.

"There was a sense of peace, even through the tough stuff, there was an underlying sense of peace."

Skill retention/use

Participants were asked at 6-months post program to reflect on their skill retention and use since they had participated in the RWP. Participants discussed skill retention and use across 7 key areas:

Active listening and communication

The most common skills participants reflected on were the active listening and communication skills they acquired as part of the RWP, and the applied value this continued to have after the program: ***"I think my biggest takeaway has been reflective listening with my teams and relationships. I don't need to solve anything, but I do need to really listen and support."*** They also spoke about the ripple effects of these skills in how they communicated and connected in their personal and professional lives, ***"The key tool I***

took from the course and one which I use regularly is listening without judgement, advice or interruption. It's allowed for deeper professional and personal connections."

Mindfulness and meditation

Many participants spoke of continuing to use mindfulness and meditation regularly, ***"I continue to use mindfulness and meditation, maybe once a week.",*** and the way this helped them to support their emotional wellbeing, ***"Not getting overwhelmed, take time to breathe, meditate. Going for a walk and enjoying the outdoors."***

Self-care and work-life balance

Participants spoke of the ways in which they had maintained or begun to embed self-care routines into their daily lives, ***"I have maintained the additional self-care activities that I set up for myself; for example I have joined a Pilates studio and have noticed greater strength in my body and focus on my core strength.",*** and how this was integral in supporting their health, wellbeing and work-life balance, ***"I have been attempting to gain more balance in my work, leisure and self-care balance, prioritising my health and tuning into what my body and mind need."***

Personal growth and coping mechanisms

A number of participants reflected on strategies they had learnt during the program, ***"When I catch myself in negative thoughts I challenge them."***, and the way in which they applied these to support their personal growth and ability to cope with stressors and challenge, ***"The biggest take away from the course is listening to your body when it's telling you enough is enough. There's no need to try and push through. And also being more in tune to your body/psych when going through the different stages and being able to recognise why it's happening"***

Journaling

A core element of the RWP includes a reflective writing exercise, and a number of participants reported continuing journaling as a helpful tool for self-reflection ***"Most days writing in my diary, taking time for myself. thinking though how I'm feeling and naming it."***

Flow-on effects

A majority of participants spoke about the flow-on effects of their participation in the program, to their relationships with and ability to support family, friends and colleagues, ***"I have used my learning's in daily interactions with family, friends and colleagues. I have felt confident in supporting fellow first responders and members of our community during traumatic events and have confidently offered support to neighbouring brigades.",*** as well as explicitly sharing learnings from the program in their personal and work lives, ***"I have been using them educate my work colleagues and immediate family so they can work towards bettering their own mental health and well-being."***

Peer support and connection

An important component of the RWP is shared experience and connection with peers, and many participants spoke of this as being a core area they enjoyed continuing, ***"I enjoy checking in regularly with my cohort via Whatsapp and with face-to-face meet ups."***. Many also talked about how they continued to support each other in the months after their participation, ***"I have checked on some of our class members and am pleased with their progress to date."***

Enablers and barriers to skill retention/use

Participant responses also highlighted a range of successful strategies for implementing and maintaining new skills, as well as some of the challenges that can arise when trying to incorporate these practices into daily life. The group-based nature of the program and associated peer support this brings, was seen as a really important facilitator for maintaining skills and sustained benefits over time. Other practical strategies related to establishing new routines, and scheduling time to revisit resources and practice skills. Occupational challenges including high workload and work-related stress, and personal relationship challenges were cited as barriers to consistent skills practice, and on a more practical note a number of participants reflected that it would be useful to have resources provided in a broader range of formats (i.e., visual, audio, web-based, hard-copy).

Enablers	Barriers
•Peer support •Establishing and maintaining new self-care routines •Regular journalling and emotional awareness •Scheduling time for skills practice and using provided resources	•Full time work as a barrier to consistent practice •Limited resource formats •Work related stress as a barrier to consistent practice •Personal relationship challenges affecting application of skills

Satisfaction and appropriateness

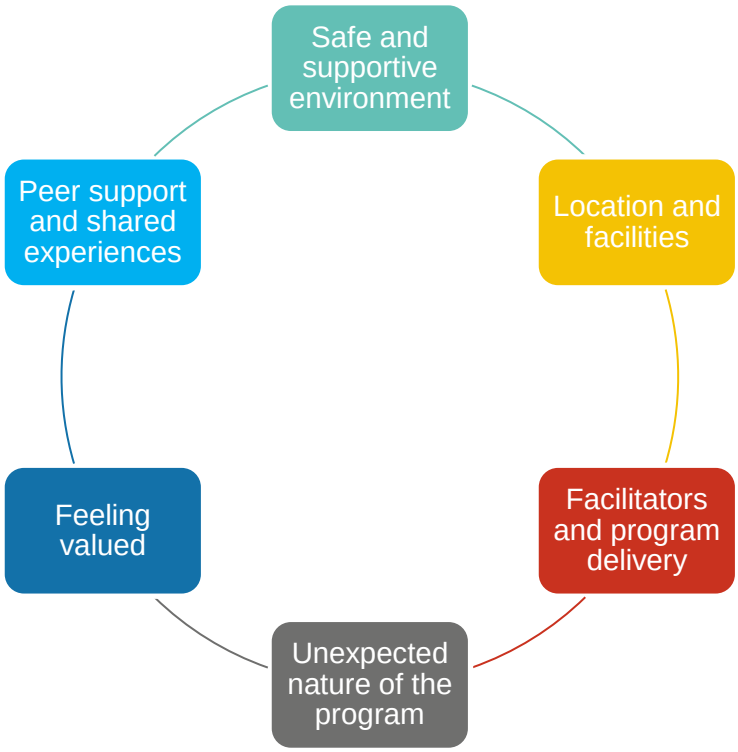
Satisfaction and appropriateness of the program was assessed through feedback from focus groups with program participants and their support people, written qualitative feedback from participants, and facilitator feedback. Focus groups were held one-month post-program, written feedback was captured at 6-month follow-up, and facilitator feedback was captured at the end of the pilot study data collection period.

Program design and delivery

When asked to reflect on the most important elements of the program that contributed to impacts from their perspective, a number of themes emerged both in terms of program design and delivery and specific program activities and components.

Important program elements

Six core themes relating to important elements of the design and delivery of the RWP that emerged from participant focus group are presented below along with a summary of each.



Location and facilities

When asked about the elements of the program that were important, many participants talked about the location and facilities. The location being separate from their organisations and removed from their day-to-day life, as well as the presence of the natural environment, all contributed to participants' ability to fully engage with the program: ***"Location for these is key, environment is key. Location and facilities were top class and certainly contribute to participants being in a better state of mind to participate. Fresh air, space, could hear waves."***. Participants also spoke of the facilities conveying a sense that they were cared for and valued: ***"Amazing location, food, environment – all of these things made them feel cared for and prioritised".***

Feeling valued

A common sentiment shared by many participants was the sense of being valued that the overall program, and how and where it was delivered, provided them; ***"You're walking into something like this feeling that maybe your organisation has forgotten about you – to have the feeling, the luxury – I felt valued".*** Participants reflected that this conveyed a ***"Real sense of being worth it – the course was developed for you and we are invested in you"***.

Safe and supportive environment

Many participants spoke of their feelings of being in a safe and supportive environment, ***"The environment and the setting made it a really safe area for us."*** and the importance of this to how they experienced and benefited from the program, and their ability to be open and fully engage with activities, ***"Liked that it provided a mutually safe environment where all participants including the trainers participated in engaging in how they felt about what others brought up for them."***

Peer support and shared experiences

The delivery of the program in a group format, with peers who had common backgrounds and experiences facilitated participants' sense of safety and ability to be vulnerable, ***"Group of people, didn't know them before, to be able to tell some stories about your life, no inhibitions, no pre judgement.", "Shared lived experience makes such a difference".***

Facilitators and program delivery

All participants spoke highly of the program facilitators, ***"The calibre of the two facilitators was just amazing. It is a huge credit to this program to have invested in such amazing professionals and experts in their field who could lead us through those vulnerable moments.",*** and the way in which the program was delivered, ***"The flexibility was important "the day takes as long as the day takes".***

Unexpected nature of the program

Limited information about what the program will involve is provided to participants and support people prior to commencement, with participants learning the key structure and components when they arrive at the location. There were mixed feelings about this lack of transparency, with many participants reflecting that the lack of information beforehand was integral to the success of the program, ***"The not knowing, the element of surprise was really important",*** while others found the lack of information and time to prepare challenging, ***"[I] struggled with not knowing what we were going to do."***

Reflections from program facilitators

Facilitators were asked to provide feedback regarding the design and delivery of the program, and any observations regarding participant experience. Their responses highlighted the importance of flexibility and the need to meet participants at their level: ***"we had to be very flexible to be able to adapt to each group, their dynamics and their level of knowledge/ insight***". The also spoke of the importance of psychological safety in allowing participants to feel comfortable enough to fully engage in program activities: ***"our ability to build rapport and make the space psychologically safe allowed people to open up and share more than participants expected to."*** Another factor that was identified as potentially contributing to program outcomes was the make-up of the group: ***"unexpectedly a mix of emergency workers from different emergency service agencies worked well. Many people said they would not have opened up as much if the entire group was from their own agency".***

Future opportunities

When asked about what types of things would have been helpful following completion of the program participants primarily talked about the desire for more regular touch points and opportunities to connect. This

also included opportunities for reflection and review. Relatedly, many suggested that more structured follow-up including prompts or reminders about skills and provision of resources, as well as access to ongoing professional support would have been beneficial. Some participants spoke of the challenges they faced following the program in transitioning back to 'regular life' and suggested that more formal processes and advice could have aided them during this time.

Return on investment (data provided by Findex)

The following section presents a summary of data, modelling and conclusions from the return-on-investment review conducted by Findex for ESF (see Appendix B for full report).

Please note that this section represents the findings and conclusions as drawn by Findex, not Phoenix Australia. This information has been used by Phoenix Australia to assist in the overall evaluative conclusions of this report.

Background

The RWP, initiated by the Emergency Services Foundation, targets the mental health and wellbeing of emergency service workers, including those with Victoria Police, Ambulance Victoria, and Fire Rescue Victoria. Given the nature of their roles and workplaces, these workers face proven elevated risk of mental health issues, with injury rates trending strongly upwards. This report evaluates the return on investment (ROI) for six pilots of the RWP conducted in 2024, each pilot costing approximately $40,000 for eight participants. The analysis demonstrates cost savings from early intervention compared to the mental health consequences of not running the program, using data from the pilots, workers' compensation data and costs, and existing research findings.

Analysis approach

Potential return on investment of the RWP were estimated through examination of program and participant cost data provided by ESF, and workcover claim data extracted from the most recent annual reports (2023/24) of Victoria's OHS regulator and provider of workplace injury insurance, WorkSafe Victoria, and emergency service agencies including Victoria Police, Ambulance Victoria, Fire Rescue Victoria and Triple Zero Victoria. Data elements utilised in the cost-benefit analysis are detailed below.

While specific data break downs across physical and mental injury claims are not reported by individual agencies, mental injury claims are far more costly than physical injury claims, involve typically far longer periods off work, and are increasing in severity and cost.

RWP program and participant costs and outcomes

The six programs in the RWP pilot cost a total of $237,724 for 48 participants, with individual program costs ranging from $37,096 to $42,573, and per participant costs ranging from $4,637 to $5,185.

Cost of Program:	**Pilot 1**	**Pilot 2**	**Pilot 3**	**Pilot 4**	**Pilot 5**	**Pilot 6**	**Average**	
Number of participant	8	8	8	8	8	8		
Facilitators	$ 25,455	$ 21,887	$ 25,471	$ 26,566	$ 21,107	$ 21,846	$ 23,722	
Accommodation & Catering	$ 15,123	$ 15,091	$ 15,127	$ 15,126	$ 15,107	$ 15,080	$ 15,109	
Printing	$ 290	$ 187	$ 166	$ 166	$ 166	$ 166	$ 190	
Wellbeing Exercise	$ 366	$ 366	$ 366	$ 366	$ 366	$ 366	$ 366	
Massage session	$ -	$ -	$ 350	$ 350	$ 350	$ 350	$ 233	
Other Costs	$ -	$ -						
Total cost	**$ 41,235**	**$ 37,531**	**$ 41,480**	**$ 42,574**	**$ 37,096**	**$ 37,808**	**$ 237,724**	**Total**
Cost per participant	$ 5,154	$ 4,691	$ 5,185	$ 5,322	$ 4,637	$ 4,726	$ 4,953	

Six months post the 8 pilot interventions; it is understood that none of the 48 participants has lodged a workers' compensation mental health claim.

Victorian Workcover claim costs

The average cost for a single workers' compensation claim across the emergency services sector exceeds substantially the cost of a RWP intervention – an intervention involving 8 participants cost $40,000. For example, the average cost of a single claim at Victoria Police is $214,578; for Ambulance Victoria $111,806; and Triple Zero Victoria is $164,013.

These claim costs are average costs for all types of claims – physical and mental. Research confirms that average mental injury costs far exceed physical claim costs, making these numbers very conservative.

WorkSafe Annual Report (2023/24):

Mental injury accounted for 18% of all WorkSafe claims (up from 16% in the prior year). Across Victoria, the average claim rate was 7.3 claims per million hours worked - up from 6.8 in 22/23.

However the Public Administration and Safety sector (which includes emergency service agencies) had a claim rate of 13.08 claims per million hours - almost double the scheme average). As shown below, the claim rates for individual emergency worker organisations far exceed both the state average and the average across the Public Administration and Safety sector.

In terms of mental injury, WorkSafe has singled out the emergency services sector (Public Administration and Safety) as an area of major concern regarding frequency and cost: *"Mental injuries continued to be a challenge in this sector and a focus for WorkSafe. (Page 29)*

Mental injury accounted for 37% of all claims across the Public Administration and Safety sector – while data is not specifically disclosed for the emergency services agencies themselves, it is more than reasonable to assume that mental injury claims account for a minimum of 37% of their claims, with all likelihood, given the nature of the work and workplaces, that the actual rate is far higher. (Page 34)

WorkSafe also reported that the average premium rate paid by employers across the scheme increased from 1.272% of remuneration, to 1.8% in 2023/24 to fund major blow outs in costs largely driven by the increased prevalence and cost of mental injury claims. Total scheme premium (ie WorkSafe premiums paid by employers) was $5billion in 2023/24, up from $3.2billion in 2022/23, with claim payments for the financial year totalling $3.6billion, compared to $3.18billion in 2022/23.

2. Ambulance Victoria Annual Report (2023/24)

Ambulance Victoria (AV) reported that their WorkSafe claim rate was 66.7 per million hours worked – more than 9 times the overall scheme average of 7.3 claims per million hours worked (claims per FTE was 10.4).

While AV does not report separately on physical and mental injury claims, anecdotally there is a a heavy exposure to mental injury within the AV workforce.

The AV premium rate of 8.59% of remuneration (with further increases projected based on caps on annual premium increases for specific employers) is well above the total WorkSafe average premium of 1.8%. The AV annual premium increased by more than $20million in 2023/24 from $43.9million to $64.5million, with an average cost per claim of $111,806. While not detailed in their annual report, existing research and analysis confirms that mental health claims are significantly more costly than physical injury claims, hence it can be assumed with absolute certainty that that the average cost of a single mental injury claim at AV is far in excess of the overall average of $111,806.

3. Victoria Police Annual Report (2023/24)

Victoria Police (VicPol) reported that their WorkSafe premium "*materially*" increased by $87.3m in 2023/24, with the premium rate increasing from 5.56% to 8.59%. This suggests the total premium paid was approximately $250million I 2023/24.

Victoria Police declared that the increase was: "*predominantly due to the rise in mental health claim injuries*".

The Vic Pol average claim injury cost was $214,578 – while the cost of mental health injuries is not separately disclosed, from previous studies it can be assumed with absolute certainty that they are significantly more costly than physical injury claims, and therefore well in excess of the $214,578average across all types of claims.

4. Fire Rescue Victoria Annual Report (2023/24)

Fire Rescue Victoria (FRV) reported that their WorkSafe premium rose by $6million in 2023/24, from $36.1 million to $43.1million..

FRV also reported a claim rate of 8.5 per 100 FTE (the claim rate per million hours worked is not disclosed) and a rise in lost time claims from 225 in 2021/22, to 258 in 2022/23, and 360 claims in 2023/24.

5. Triple Zero Victoria Annual Report (2023/24)

Triple Zero Victoria (TZV) reported that their "Lost Time Injury Frequency Rate", a rate which refers to the number of incidents resulting in time lost from work of one day/ shift or more (per one million hours worked), rose from 36.5 in 2021/22, to 44.1 in 2022/23, to 51.9 in 2023/24.

TZV also reported that their average cost per claim rose from $142k in 2021/22, to $144k in 2022/23, to $164k in 2023/24.

Claim risk and cost estimates

Scenario 1. Claim Risk & Cost Snapshot

	Vic Pol	**AV**
Claim rate (per 100 FTEs)	6.22	10.4
Mental injury % (baseline)	37%	37%
Avg. claim cost	$214,589	$111,806
Expected claims (80 ppl)	**1.84**	**3.07**
Expected cost (conservative)	**$394,843**	**$344,183**

Total expected claim cost targeted (conservative): $739,026

Scenario 2. Adjusted (Realistic) Scenario

Assumptions:

- Claim rate +25% due to higher-risk cohort
- Mental injury % = increased form 37% to 45% due to higher risk profession compared to Public Administration and Safety industry average
- Mental injury claims 50% more costly than average claim cost

	Vic Pol	**AV**
Adjusted claim rate per 100FTE	7.7	13
Mental injury claim rate	3.47	5.85

Avg. mental injury cost	$321,883	$167,709
Expected claims (80 ppl)	**2.77**	**4.68**
Expected cost (realistic)	**$892,259**	**$784,878**

Total expected claim cost targeted (realistic): $1.68 million

The above analysis DOES NOT include the benefit of additional cost areas being potentially avoided/reduced:

1. Productivity
2. Recruitment & Training
3. Supervisory & HR Time
4. Legal and Dispute Costs

The above analysis DOES NOT include potential additional value / savings delivered through:

1. Improved Workforce Wellbeing & Engagement
2. Enhanced Service Delivery
3. Reputation and Compliance

Findex conclusion and recommendations

The RWP shows great promise as a cost-effective early intervention, with potential savings deriving from reduced mental health-related costs, improved retention, and prevented WorkCover claims.

It is recommended that emergency service agencies invest to expand the RWP to enable further and ongoing refinement of cost-effectiveness estimates, with a view to establishing a permanent program across the sector.

Mapping the outcomes against the stated purpose of the RWP

Stated purpose of the RWP	Evaluation outcomes
Assist serving emergency workers to understand the mechanisms and effects of operational stress on the body, the brain, on behaviour and on relationships.	Participants reported increased knowledge and understanding of the mechanisms and effects of operational stress on the body, the brain, on behaviour and on relationships.
Provide opportunity to discuss the impact of personal emergency response experiences with peers in a systemic and professionally facilitated environment.	The program provided participants with the opportunity to discuss impacts of their personal emergency response experiences with their peers in a safe and supportive environment.
Equip participants with skills for self-regulation, effective communication, and planning strategies to maintain their resilience while facing ongoing operational challenges.	Participants reported improved emotion regulation and communication skills that were able to be applied in both personal and operational contexts and relationships.
Help minimise progression to serious mental injury and WorkCover claims.	Participants had significant reductions in self-reported mental health symptoms and improvements in self-reported functional impairment and quality of life, which were sustained up to 6 months post-program. In order to determine the extent to which progression to serious mental injury and/or Workcover claims is minimised through participation in the RWP, further evaluation including a larger sample, appropriate administrative metrics and longer participant follow-up is recommended.
Demonstrate through evaluation the benefit of such an early intervention initiative for participants, families and organisations.	Outcomes of the evaluation provide clear evidence of beneficial impacts for individuals who participated in the program, which are likely to have beneficial flow-on effects within personal, family and occupational contexts.

Evaluative conclusions

Program effectiveness

Outcomes of the evaluation showed **significant short-term improvements** across measures of mental health and wellbeing, functioning, quality of life and presenteeism, and for the most part these improvements were **sustained up to 6 months post-program**. At this stage it is unknown whether these improvements will translate to the long term prevention of mental disorder in this population, however these pilot results are encouraging.

Qualitative insights from participants and support people further demonstrated program impact and effectiveness, including that the **program provides participants with valuable skills that they continue to use months after completion**. The **group-based approach, and associated peer support appear to be integral** to supporting and facilitating long-term skill retention and application.

Positive impacts were also reported in personal relationships and home life, as well as occupational contexts with most participants and many support people noting the program's broader impact on participants' personal and professional relationships, indicating its value beyond individual skill development. Both participants and support people observed improvements in communication and connection and reported **flow-on effects in supporting others and educating colleagues and family**.

While the program was designed for individuals with early to subthreshold mental health issues as an early intervention approach, it appears to have also been beneficial for a subset of participants who had more severe mental health symptoms. It is important to recognise that this subgroup underwent clinical review and interview prior to acceptance into the program, so do not necessarily represent a typical population with mental disorder. Future evaluation of the program should consider if a broader range of participants are to be included, whether there is a need for modifications to the intervention (such as greater post-program support) that might be necessary to better serve this broader population, and utilising a stratified design that explicitly includes both groups and is powered to detect differences between them.

Satisfaction and appropriateness

Outcomes of the evaluation indicated **very high satisfaction among participants**, with the program design and delivery **perceived to be appropriate** for the target population. The program was successful in creating a **safe, valuable and transformative experience** for participants, with the location, peer support and expert facilitation integral to this. These program elements contributed to participants feeling valued and supported, which in turn enabled them to fully engage with the program content.

Participants reported very **high levels of satisfaction and advocacy for the program**, however there were some **opportunities for improvement identified**. These include the need for more structured post-program support, including regular check-ins, skill reminders, and ongoing professional/clinical support. Implementing these additional elements could further enhance program impacts and help participants adjust following program completion. This aligns with other research into residential retreat interventions, which underscores the importance of booster sessions over time to reinforce skill and knowledge acquisition.

A final area that emerged from participant feedback was the role of the organisation in providing the appropriate structures and conditions to support good mental health and recovery, including support both pre-and post-program to maximise the benefits of the RWP. In particular, participants noted that **workplace stress and workload were barriers to sustaining learnings gained from their participation in the RWP.** Considering how this type of intervention may fit into the broader psychosocial hazard reduction and mitigation, and mental health and wellbeing strategies within organisations will be important for future roll-out of the program.

Return-on-investment

The return-on-investment review undertaken by Findex showed **preliminary evidence that the program costs per participant are relatively modest when compared with the potential costs associated with workers compensation claims in Victoria**. Findex concluded that the **program shows great promise** as a cost-effective early intervention, with potential savings from reduced mental health-related costs, improved retention, and prevented WorkCover claims. While this evaluation was not able to determine whether observed program benefits will be sustained in the longer term, and translate into reductions in Workcover claims, reduced mental health related costs or improved retention, findings do show improvements in mental health and presenteeism which may plausibly translate to these proposed cost savings.

Limitations and future considerations

There were a number of limitations to this evaluation that should be acknowledged. First, this was a pilot, and as such utilised a pre-post-post evaluation design, with no control group, thus it is not possible to definitively establish the causative role of participation in the RWP on outcomes. However, the rich qualitative data highlight the benefits from the perspective of both participants and their support people, including the specific program components and activities that they believe contributed to improvements across a broad range of mental health and wellbeing indicators. The limited follow-up period (6 months), and lack of other objective indicators of medium to long-term effectiveness (such as worker retention, absenteeism, future mental health needs, workers compensation claims) limit the ability to determine whether these improvements will translate to long term prevention of mental disorder in this population.

The heterogeneity of the participant sample, in particular through inclusion of individuals with probable or diagnosed mental disorder limits the findings in a number of ways: (a) heterogeneity of the sample has the potential to have diluted true effects of the intervention for the target population, although supplementary subgroup analyses suggest similar magnitude improvements across the different groups. However, the small sample size means these results should be considered with caution; (b) the evaluation findings reported here may not be generalisable to the target population with early to subthreshold mental health symptoms, and this should be considered in future roll-out of the program. For example, many participants spoke about the need for further professional support in the 6-months following the program. It is possible that these responses in part reflect the greater support needs of individuals with probable or diagnosed mental disorder; (c) relatedly, the program in its current form was not designed to meet the more complex needs of individuals with diagnosed disorder, who are likely to require more intensive and different types of support.

The return-on-investment review only included limited variables in analysis and did not consider other costs that may be incurred through participation in the program, including time out of the workforce to participate

(and associated staff replacement costs), and the potential for additional costs to the employer through participants engaging in active treatment following their participation. For some participants, engagement with the RWP may serve as an important pathway to care and prompt further help-seeking in individuals who may otherwise have delayed seeking assistance. Finally, while the evaluation does suggest that there are benefits to participants, this does not mean that none of those participants will go on to make a future compensation claim. Future roll-out of the program to a larger sample, utilising a more rigorous control-group methodology and including linkage with relevant administrative data sources will allow for firmer conclusions regarding the cost-benefits of the program to be determined.

The positive outcomes for participants and high levels of satisfaction and advocacy for the program are very encouraging, however it is important to recognise that participants self-selected into the program, therefore may be particularly motivated. Individuals who opted into the program may also represent those with a preference for group-based activities, and it is not known whether this approach would be the most appropriate for all individuals.

Implications and recommendations

The outcomes of this evaluation show that the Victorian RWP has potential as an early or adjunct intervention option for emergency services workers who have emerging and subthreshold mental health issues. The utility and applicability of this program for individuals with more severe mental health issues requires further investigation, however initial findings suggest it may be beneficial.

Importantly, participation in the RWP was not associated with any harmful outcomes, with most participants reporting improved mental health, functioning, quality of life and presenteeism. **Participant feedback was overwhelmingly positive and high levels of advocacy for the program were observed**, indicating that for those individuals who have a preference for group-based interventions the program is highly acceptable.

Initial data also suggest that the benefits of the program extend beyond the individual, with many participants reporting the flow-on effects of their participation into (a) the way they communicate and engage with family, peers, and colleagues, and (b) through sharing their learnings and providing support to others. Future research to better understand this flow-on effect at the team and organisation level, will aid with better realising the potential benefits. Relatedly, any intervention sits within a system, and while early intervention is an important component of addressing psychosocial hazards of high-risk occupations such as emergency services, it is equally important that organisations consider where the intervention sits within and how it relates to their overall mental health and wellbeing strategy.

The return-on-investment review was necessarily limited, however provided an indication of the potential cost savings for organisations. A more detailed examination of actual costs incurred by organisations due to the full spectrum of mental health issues (such as absenteeism, utilisation of workplace mental health programs, Workcover claims for mental health), a more nuanced examination of potential costs of participation in the RWP, and costs of alternative mental health interventions, alongside potential benefits that extend beyond the individual, to the organisation and sector more broadly, should be undertaken.

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Appendix A – Detailed measures

Measures

Self-report measures of participant mental health, wellbeing and functioning

Psychological distress

Psychological distress was assessed using the 10-item Kessler distress scale (K10). The K10 is a widely used and validated measure of non-specific distress measured over the past four weeks (Ursano et al., 2018). Responses are scored on a five-point scale (where 5 = all of the time, and 1 = none of the time). Scores were summed to create a total score, where higher scores are indicative of higher psychological distress.

Posttraumatic Stress Disorder (PTSD) symptoms

PTSD symptoms were assessed using the Posttraumatic Stress Disorder Checklist for DSM-5 (Weathers, et al., 2013). The PCL-5 is a 20-item self-administered questionnaire which has been widely used for assessing PTSD symptoms in the past month. Participants were asked to rate how much they had been bothered by symptoms of PTSD in the past month on a 5-point scale from 0 ‘not at all’ to 4 ‘extremely’. A total symptom severity score was obtained by summing scores across items to give a score between 0 and 80, whereby higher scores indicate greater severity of PTSD symptoms.

Social support

Social support from friends, family, colleagues and leadership/supervisor using an adapted version of the Schuster Social Support Scale (Schuster, Kessler, & Aseltine, 1990). Affective support was indicated by responses to questions about how often family/friends made them feel cared for and how often family/friends expressed interest in how they were doing. Negative interactions were indicated by responses to questions about how often family/friends made too many demands on them, how often they criticised them and how often they created tensions or arguments with them. All items were answered on 4-point Likert-type scale ranging from 0 ‘never’ to 3 ‘often’. Negative items were reverse coded and scores on the five items were summed separately for the four domains, creating four total scores. Higher scores indicate higher levels of social support.

Functional impairment

Functional impairment was assessed via the Sheehan Disability Scale (Sheehan, 1983). Participants were asked four items about their level of disability due to mental health symptoms in four inter-related domains; home management, work, relationships and social. Responses were on a scale from 1 ‘No interference’ to 5 ‘Very severe interference’ and yield a total global functional impairment score of between 4 and 20. Higher scores indicate greater functional impairment.

Quality of life

Quality of life was assessed using the WHOQOL-BREF (The WHOQOL Group, 1998). The WHOQOL-Brief is a 26-item measure asking about quality of life in four domains: physical health, psychological, social

relationships and environment. In addition, two items assessing overall quality of life and health and included. Responses are on varying 5-point scales with scores of 1 to 5. The mean of items in each domain is calculated and multiplied by four to produce a score ranging from 4-20, comparable with the WHOQOL-100. Higher scores indicate greater quality of life.

Presenteeism

Presenteeism was assessed using the 6-item Stanford Presenteeism Scale (SPS-6; Koopman et al., 2002). Participants were asked three positively worded questions (e.g. Despite my mental health, I was able to finish hard tasks in my work) and three negatively worded questions (e.g. Because of my mental health, the stresses of my job were much harder to handle) regarding how their mental health impacted their work. Responses were on a 5-point scale from 1 'Strongly disagree' to 5 'Strongly agree'. Negative items were reverse coded and scores on the six items were summed to create a total score. Higher scores indicate a greater ability to concentrate and accomplish work despite mental health problems, meaning a higher level of presenteeism.

Qualitative data

Post-program focus groups

Part 1: General program feedback

1. What did you think of the program?
2. Have you spoken to anyone at work or home about your experience in the program? (If so, what were some of the things you shared, if not, is this something you are thinking of doing)
3. Do you feel like you have been able to apply the skills you have learnt? (at work)

Part two: Program review

4. What aspects of the program did you like the most / least?
5. Is there anything about the program that you would change?

Part three: Program connectedness

6. Have you connected with other participants of the program since your participation?
7. Would you recommend this program to others in your workplace? Who do you think it is best suited for?

Part 4: Significant others (if there)

8. Can you share any impacts of the program that you have observed?

Written feedback 6-months post-program

1. In the time since you attended the program, have you been using the skills that you learnt? (could you explain how you have been using them, or if you havent, why not?)
2. Is there anything you think would be helpful for attendees once they have completed the program (i.e., between finishing and now 6 months later)?
3. As the independent evaluators for this program, is there anything else you think it would be good for us to know?

Facilitator feedback

1. Did you feel adequately prepared for providing this program to emergency service members?
2. Did you experience any challenges in delivering this program?
3. Do you feel that this program adequately engaged and met the needs of those who participated?
4. Do you think there are groups or cohorts that this program would particularly benefit?
5. Were there any components of program in particular that stood out as being beneficial for certain types of individuals? (trying to get to the group make up, i.e. were there particular group make ups that worked better)
6. Do you have any suggestions for how this program could be improved?

Appendix B - Findex Return on Investment Review

Emergency Services Foundation
Residential Wellbeing Program | Pilot

Return on Investment Review | May 2025

Key Points

- Research suggests the Emergency Services Foundation "Residential Wellbeing Program" (RWP) has strong potential to improve the mental health of participating emergency service workers, with consequent reductions workers' compensation claims and associated direct and indirect financial costs.
- The financial analysis of the RWP Pilot supports its expansion on the basis of net potential financial savings - the average cost of a single workers' compensation claim at Victoria Police is $214,578 (2023/24 Annual Report), while the cost of a single pilot program for 8 emergency workers is $40,000.
- See Appendix 1 for a Business Case to expand the pilot by a further 20 programs, at a cost of $800,000 for an estimated potential claim cost saving alone, of up to $1.68million.
- This potential benefit does not include other additional cost areas potentially avoided or reduce by the program, including productivity impacts, sick leave, recruitment and training, time spent managing claims, improved workforce wellbeing and engagement, enhanced service delivery and reduction in reputational risk.

Program Overview

The Residential Wellbeing Program (RWP), run by the Emergency Services Foundation, is a four-day intensive skill development intervention aimed at enhancing mental health and wellbeing for emergency service worker, including Victoria Police, Ambulance Victoria, Fire Rescue Victoria and Triple Zero Victoria. Six pilots were conducted in 2024, for a total Pilot cost of $240,000.

Cost and Benefits

While specific data break downs across physical and mental injury claims are not reported by individual agencies, mental injury claims are far more costly than physical injury claims, involve typically far longer periods off work, and are increasing in severity and cost.

The Victoria Police overall rate of workers' compensation claims per FTE in 2023/24 was 6.22, with an average claim cost of $214,578 (Victoria Police Annual Report).

The rate of all claims amongst Ambulance Victoria employees was 10.4 per 100 FTE, with an average cost of $111,806 (AV Annual Report, 2023/24).

A significant proportion of these overall claims relate to mental wellbeing.

WorkSafe Victoria in its 2023/24 Annual report discloses that 37% of claims within the industry classification 'Public Administration and Safety' (which includes but is not restricted to, emergency service organisations) relate to mental injury, with mental injury claims driving major premium increases in recent years.

According to Victoria Police: "*the annual WorkCover Premium rate increased from 5.56 per cent to 8.59 per cent in the year, **predominantly due to the rise in Mental Health claim injuries**.*"

As such, existing research and initial evaluation of the RWP Pilot program suggests a strong potential for a positive return on investment in an expanded RWP program.

A RWP intervention costs on average $40,000, across 8 participants, or $5000 per participant. Running 20 intervention involving 160 employees, for example 80 from Victoria Police and 800 from Ambulance Victoria, would cost $800,000.

Across a group of 80 Ambulance Victoria employees, based on 2023/24 data approximately 8 can be expected to lodge a claim in the next 12 months, with an average cost in excess of $111,000, for a total of more than $888,000.

Across 80 Victoria Police employees, on average 5 will lodge claims in the next 12 months, with an average cost in excess of $214, 578 per claim, for a total cost of more than $1.06 million.

While these total costs include both physical and mental injury claims, they also include an average cost across all claims, which significantly understates the actual claim cost of a mental injury. According to WorkSafe Victoria: "Only 40% of workers with a mental injury are back at work within six months. This is compared to 73% of workers with a physical injury."

In addition, the assumed future claim rate is based on the 'average' emergency services employee – the RWP is tailored to those identified as being more at risk of developing a mental wellbeing injury, and therefore with a higher likelihood of lodging a mental wellbeing claim.

Appendix 1 details the Business Case for a pilot extension using both 'very conservative' data, and more realistic, but still considered conservative, assumptions.

Appendix 2 details data extracted from the 2023/24 Annual Reports of Victoria's OHS regulator, WorkSafe Victoria and individual emergency service agencies, that is if relevance to the Business Case supporting the expansion of the RWP pilot.

Conclusion

An expansion of the RWP early intervention pilot for the Victorian emergency services sector would represent a strategic investment in workforce health, financial sustainability, and operational resilience.

It is a clear, evidence-based opportunity to address rising mental injury claims in an exceptionally cost-effective manner and is aligned with public sector priorities on psychological health, workforce sustainability, and injury prevention.

Even under cautious modelling, the **program's targeted benefits outweigh costs**, offering potential for major reductions in claim incidence, severity and cost, highlighting a strong case for investment in early intervention.

Report: Return on Investment Analysis for the Residential Wellbeing Pilot Program undertaken in 2024

Executive Summary

The Residential Wellbeing Program (RWP), initiated by the Emergency Services Foundation, targets the mental health and wellbeing of emergency service workers, including those with Victoria Police, Ambulance Victoria, and Fire Rescue Victoria. Given the nature of their roles and workplaces, these workers face proven elevated risk of mental health issues, with injury rates trending strongly upwards. This report evaluates the return on investment (ROI) for six pilots of the RWP conducted in 2024, each pilot costing approximately $40,000 for eight participants. The analysis demonstrates cost savings from early intervention compared to the mental health consequences of not running the program, using data from the pilots, workers' compensation data and costs, and existing research findings. The pilot evaluation suggests strongly that it has delivered significant potential for benefits to more than offset program total costs. An expansion of the pilot program beyond the initial 8 interventions would facilitate a deeper evaluation to further refine the cost-benefit analysis.

ESF Pilot Outcomes

- The ESF six pilots cost a total of $237,724 for 48 participants, with individual pilot costs ranging from $37,096 to $42,573.

Cost of Program:	Pilot 1	Pilot 2	Pilot 3	Pilot 4	Pilot 5	Pilot 6	Average	
Number of participant	8	8	8	8	8	8		
Facilitators	$ 25,455	$ 21,887	$ 25,471	$ 26,566	$ 21,107	$ 21,846	$ 23,722	
Accommodation & Catering	$ 15,123	$ 15,091	$ 15,127	$ 15,126	$ 15,107	$ 15,080	$ 15,109	
Printing	$ 290	$ 187	$ 166	$ 166	$ 166	$ 166	$ 190	
Wellbeing Exercise	$ 366	$ 366	$ 366	$ 366	$ 366	$ 366	$ 366	
Massage session	$ -	$ -	$ 350	$ 350	$ 350	$ 350	$ 233	
Other Costs	$ -	$ -						
Total cost	**$ 41,235**	**$ 37,531**	**$ 41,480**	**$ 42,574**	**$ 37,096**	**$ 37,808**	**$ 237,724**	**Total**
Cost per participant	$ 5,154	$ 4,691	$ 5,185	$ 5,322	$ 4,637	$ 4,726	$ 4,953	

Six months post the 8 pilot interventions; it is understood that none of the 48 participants has lodged a workers' compensation mental health claim.

The average cost for a single workers' compensation claim across the emergency services sector exceeds substantially the cost of a RWP intervention – an intervention involving 8 participants cost $40,000. For example, the average cost of a single claim at Victoria Police is $214,578; for Ambulance Victoria $111,806; and Triple Zero Victoria is $164,013.

These claim costs are average costs for all types of claims – physical and mental. Research confirms that average mental injury costs far exceed physical claim costs, making these numbers very conservative.

Conclusion and Recommendations

The RWP shows great promise as a cost-effective early intervention, with potential savings deriving from reduced mental health-related costs, improved retention, and prevented WorkCover claims.

It is recommended that emergency service agencies invest to expand the RWP to enable further and ongoing refinement of cost-effectiveness estimates, with a view to establishing a permanent program across the sector.

APPENDIX 1.

Early Intervention Pilot: Business Case for Expansion

Victoria Police & Ambulance Victoria | 2025

Overview

This business case proposes an early intervention program targeting mental injury prevention in frontline roles at **Victoria Police (Vic Pol)** and **Ambulance Victoria (AV)**. It focuses on higher-risk individuals identified through screening and aims to reduce the likelihood and cost of mental injury claims through structured, evidence-based programs.

Program Summary

- **Total Participants:** 160 frontline staff (80 AV + 80 Vic Pol)
- **Delivery Model:** 20 group-based programs (10 per agency × 8 participants)
- **Total Cost: $800,000** ($400,000 per agency)

Scenario 1. Claim Risk & Cost Snapshot

	Vic Pol	AV
Claim rate (per 100 FTEs)	6.22	10.4
Mental injury % (baseline)	37%	37%
Avg. claim cost	$214,589	$111,806
Expected claims (80 ppl)	**1.84**	**3.07**
Expected cost (conservative)	**$394,843**	**$344,183**

Total expected claim cost targeted (conservative): $739,026

Scenario 2. Adjusted (Realistic) Scenario

Assumptions:

- Claim rate +25% due to higher-risk cohort
- Mental injury % = increased form 37% to 45% due to higher risk profession compared to Public Administration and Safety industry average
- Mental injury claims 50% more costly than average claim cost

	Vic Pol	AV
Adjusted claim rate per 100FTE	7.7	13
Mental injury claim rate	3.47	5.85
Avg. mental injury cost	$321,883	$167,709
Expected claims (80 ppl)	**2.77**	**4.68**
Expected cost (realistic)	**$892,259**	**$784,878**

Total expected claim cost targeted (realistic): $1.68 million

The above analysis DOES NOT include the benefit of additional cost areas being potentially avoided/reduced:

1. Productivity
2. Recruitment & Training
3. Supervisory & HR Time
4. Legal and Dispute Costs

The above analysis DOES NOT include potential additional value / savings delivered through:

1. Improved Workforce Wellbeing & Engagement

2. Enhanced Service Delivery

3. Reputation and Compliance

Key Takeaways

- The program has potential benefits of up to $1.68million conservatively, with the potential **offset its own cost under even conservative modelling**.
- Under realistic assumptions, potential **savings exceed 2× program cost**.
- Delivers measurable risk reduction in high-exposure roles.
- Aligns with sector goals on workforce wellbeing and sustainable injury prevention.

Conclusion

This early intervention pilot is a strategic investment in workforce health, financial sustainability, and operational resilience. It presents a clear, evidence-based opportunity to address rising mental injury claims in Victoria's emergency services.

APPENDIX 2.

Data supporting the Business Case for pilot expansion

The Business Case in Appendix 1 draws on relevant data extracted from the most recent annual reports (2023/24) of Victoria's OHS regulator and provider of workplace injury insurance, WorkSafe Victoria, and emergency service agencies including Victoria Police, Ambulance Victoria, Fre Rescue Victoria and Triple Zero Victoria.

1. WorkSafe Annual Report (2023/24):

Mental injury accounted for 18% of all WorkSafe claims (up from 16% in the prior year). Across Victoria, the average claim rate was 7.3 claims per million hours worked - up from 6.8 in 22/23.

However the Public Administration and Safety sector (which includes emergency service agencies) had a claim rate of 13.08 claims per million hours - almost double the scheme average). As shown below, the claim rates for individual emergency worker organisations far exceed both the state average and the average across the Public Administration and Safety sector.

In terms of mental injury, WorkSafe has singled out the emergency services sector (Public Administration and Safety) as an area of major concern regarding frequency and cost:

"Mental injuries continued to be a challenge in this sector and a focus for WorkSafe. (Page 29)

Mental injury accounted for 37% of all claims across the Public Administration and Safety sector – while data is not specifically disclosed for the emergency services agencies themselves, it is more than reasonable to assume that mental injury claims account for a minimum of 37% of their claims, with all likelihood, given the nature of the work and workplaces, that the actual rate is far higher. (Page 34)

WorkSafe also reported that the average premium rate paid by employers across the scheme increased from 1.272% of remuneration, to 1.8% in 2023/24 to fund major blow outs in costs largely driven by the increased prevalence and cost of mental injury claims. Total scheme premium (ie WorkSafe premiums paid by employers) was $5billion in 2023/24, up from $3.2billion in 2022/23, with claim payments for the financial year totalling $3.6billion, compared to $3.18billion in 2022/23.

2. Ambulance Victoria Annual Report (2023/24)

Ambulance Victoria (AV) reported that their WorkSafe claim rate was 66.7 per million hours worked – more than 9 times the overall scheme average of 7.3 claims per million hours worked (claims per FTE was 10.4).

While AV does not report separately on physical and mental injury claims, anecdotally there is a a heavy exposure to mental injury within the AV workforce.

The AV premium rate of 8.59% of remuneration (with further increases projected based on caps on annual premium increases for specific employers) is well above the total WorkSafe average premium of 1.8%. The AV annual premium increased by more than $20million in 2023/24 from $43.9million to $64.5million, with an average cost per claim of $111,806. While not detailed in their annual report, existing research and analysis confirms that mental health claims are significantly more costly than physical injury claims, hence it can be assumed with absolute certainty that that the average cost of a single mental injury claim at AV is far in excess of the overall average of $111,806.

3. Victoria Police Annual Report (2023/24)

Victoria Police (VicPol) reported that their WorkSafe premium "*materially*" increased by $87.3m in 2023/24, with the premium rate increasing from 5.56% to 8.59%. This suggests the total premium paid was approximately $250million I 2023/24.

Victoria Police declared that the increase was: "*predominantly due to the rise in mental health claim injuries*".

The Vic Pol average claim injury cost was $214,578 – while the cost of mental health injuries is not separately disclosed, from previous studies it can be assumed with absolute certainty that they are significantly more costly than physical injury claims, and therefore well in excess of the $214,578average across all types of claims.

4. Fire Rescue Victoria Annual Report (2023/24)

Fire Rescue Victoria (FRV) reported that their WorkSafe premium rose by $6million in 2023/24, from $36.1 million to $43.1million..

FRV also reported a claim rate of 8.5 per 100 FTE (the claim rate per million hours worked is not disclosed) and a rise in lost time claims from 225 in 2021/22, to 258 in 2022/23, and 360 claims in 2023/24.

5. Triple Zero Victoria Annual Report (2023/24)

Triple Zero Victoria (TZV) reported that their "Lost Time Injury Frequency Rate", a rate which refers to the number of incidents resulting in time lost from work of one day/ shift or more (per one million hours worked), rose from 36.5 in 2021/22, to 44.1 in 2022/23, to 51.9 in 2023/24.

TZV also reported that their average cost per claim rose from $142k in 2021/22, to $144k in 2022/23, to $164k in 2023/24.

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