**Submission No 194**

# INQUIRY INTO EMERGENCY SERVICES AGENCIES

**Organisation:** Rape & Domestic Violence Service Australia

**Date Received:** 22 May 2018

Rape & Domestic Violence Services Australia

Formerly NSW Rape Crisis Centre

# 24/7 Telephone Counselling Service

*"Trauma is an experience that overwhelms our ability to cope and leaves our relationships and our brains with the challenge of finding a way to remain integrated and functioning well"* (Daniel J. Siegel, Foreword to Shapiro, 2010).

May 2018

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## Executive Summary

The NSW Parliamentary Inquiry into Emergency Services found that;

- Paramedics experience seven times the risk of workplace serious injury,
- Firefighters report 20% higher rates of work-related Post Traumatic Stress Disorder (PTSD),
- The risk of exposure to injury, threat and death is highest for Emergency Services workers,
- 110 Emergency Services workers committed suicide between 2000 and 2012
- Workplace culture reduces likelihood of workers seeking help for trauma impacts, and
- Remote locations further reduce access to support services.

It is proposed that;

- A PTSD, Secondary Traumatic Stress and Vicarious Trauma specialist 24/7 telephone counselling service for Emergency Service workers be established,
- the service provide training for Emergency Services to increase early intervention, and
- the service be provided by Rape & Domestic Violence Services Australia.

The 24/7 Telephone Counselling Service will assist Emergency Services and Emergency Service workers to develop a culture and strategies to better manage the impacts of PTSD, Secondary Traumatic Stress and Vicarious Trauma. This will reduce the potential for the impacts to become injuries. A key strategy will be access to the 24/7 specialist trauma counselling service. Outcomes may include a reduction in resignation, sick leave, workplace disruption, psychological injury and workers' compensation claims.

The service model will be evidence-based. It will situate PTSD, Secondary Traumatic Stress and Vicarious Trauma as inevitable impacts of working in a trauma environment.

While the causation of PTSD, Secondary Traumatic Stress and Vicarious Trauma are different, the impacts are similar, but may vary in severity.

The 24/7 Telephone Counselling Service will provide crisis intervention, brief empathic support, strategies to assist in containing overwhelm and acute distress, psycho-education, and referral.

The therapeutic models underpinning the work will be Stepped Care, Stages of Trauma Recovery, Transtheoretical Model of Change and Crisis Intervention.

Rape & Domestic Violence Services Australia is best placed to provide the Service as it has an evidence-based trauma counselling practice, a 24/7 telephone trauma counselling workforce, 45 years experience in working with traumatised populations, and has developed an award-winning Vicarious Trauma management program that has halved sick leave and resulted in no workers' compensation claims against the organisation for psychological injury in 15 years.

## Definitions

It is noted in the literature that the following terms are often used interchangeably. For the purpose of this submission the following terms and definitions will be used.

| | |
|---|---|
| **Crisis** | Human psychological crises come in many forms and for many reasons. Crisis can be defined as a perception or experience of an event or situation as an intolerable difficulty that exceeds the person's current resources and coping mechanisms (James and Gilliland, 2001). |
| **Post Traumatic Stress Disorder** | PTSD is a cluster of psychological and emotional symptoms that can impact a person when they experience a life-threatening event. For example, an ambulance officer is attacked by a patient, a police officer has a gun pointed at them, and a firefighter is in a burning building that is disintegrating. |
| **Secondary Traumatic Stress** | Secondary Traumatic Stress is the impact on someone of witnessing someone else's life threatening or traumatic event. For example, an emergency services worker attends a scene where others are seriously injured and/or dead. |
| **Vicarious Trauma** | "Vicarious Trauma is the detrimental impact on workers who are exposed to traumatic information or events. Traumatic information includes stories of abuse, violence, torture, neglect or disaster. Police, firefighters, ambulance workers, counsellors, mental health professionals, hospital staff, judicial system staff, child protection workers and law practitioners are examples of staff that will be impacted by vicarious trauma." |

Symptoms that can be experienced by someone impacted by PTSD, Secondary Traumatic Stress and/or Vicarious Trauma are commonly referred to in four clusters:

| **Cluster** | **Common Symptoms** |
|---|---|
| Re-experiencing | Intrusive images, thoughts, memories; recurrent dreams; hallucinations, flashbacks; intense distress at re-experiencing. |
| Avoidance | Avoidance of associated thoughts, feelings, conversations, activities, places, people; many forms of dissociation including amnesia; diminished interest in activities; feeling disconnected; restricted emotions; sense of foreshortened future. |
| Arousal | Difficulty sleeping; irritability or angry outbursts; difficulty concentrating; hyper-vigilance; exaggerated startle response. |
| Cogitative Change | Frame of reference changes in relation to identity, world view, spirituality; reduced ability to manage strong feelings; feel not entitled to life and love; reduced capacity or overly responsible in caring for others. |

## The Problem

When compared with the national workforce;

- Paramedics experience seven times the risk of serious injury,
- Firefighters report 20% higher rates of work-related Post Traumatic Stress Disorder (PTSD),
- The risk of exposure to injury, threat and death is higher for emergency services workers, and
- Workplace culture reduces the likelihood of workers seeking help.

The *Audit Office Key Finding Report on the NSW Police Force (2017)* found 87% of claims for income protection payments were for psychological injury.

The *Audit Office Key Finding Report on Fire and Rescue Services (2017)* identified Post Traumatic Stress Disorder as a significant injury.

The NSW Government inquiry into Emergency Services Agencies uncovered substantive evidence of impacts of exposure to acutely stressful and traumatic experiences for emergency services workers.

The inquiry also heard from workers and agency officials about problems associated with workers accessing support services and the need for integrated and easily accessible services

In Australia between July 2000 and December 2012, 110 emergency services workers committed suicide (National Coronial Information System 2012, Beyond Blue, p. 10). They were police officers, paramedics and firefighters. The actual number is likely to be higher as suicide, as a cause of death, is under-reported.

For every death by suicide in Australia, it is estimated that thirty people attempt suicide (Lifeline website). As rates of PTSD amongst emergency services workers are higher than the general population, and as risk of suicide increases as mental ill health worsens, it is reasonable to hold concerns about the risk of suicide amongst emergency services workers. This PTSD impact is further amplified by the Secondary Traumatic Stress and Vicarious Trauma impact that emergency services workers will experience.

The World Health Organisation has identified that having access to the means to complete suicide (drugs, weapons etc.), as many emergency services workers do, is a major risk factor for suicide (WHO 2014, Beyond Blue, p. 10).

PTSD mental health impacts, Secondary Traumatic Stress and Vicarious Trauma can have wide ranging consequences on overall functioning and quality of life. Work related PSTD symptoms,

secondary traumatic stress and Vicarious Trauma can impact personal and family relationships, ability to perform work duties, physical health, income and career pathways.

PTSD impacts include:

- Intrusive memories such as nightmares and flashbacks,
- Arousal such as hypervigilance, sleep disturbances, anxiety and startled responses,
- Avoidance of places, people and events that remind the person of the traumatic event e.g. work, and
- Cognitive change, including beliefs that 'the world is no longer safe' and 'people, including work colleagues, are bad'.

Secondary Traumatic Stress and Vicarious Trauma impacts are different in causation (see definitions page 4). While generally less severe, the impacts mirror PTSD impacts. Secondary Traumatic Stress and Vicarious Trauma impacts can be accumulative leading to severe mental health impacts and workers' compensation claims for psychological injury.

PTSD, Secondary Traumatic Stress and Vicarious Trauma can be accompanied by a co-morbidity of mental health difficulties such as depression and substance use. Such impacts can range from moderate to severe.

Like many mental health difficulties the complexity of overlapping symptoms and the stigmatisation of mental ill health, compounded by the expectation of emergency services workers that they be hyper-resilient, can result in workers experiencing considerable obstacles to seeking help.

Where early intervention is not accessed or not accessible, the impacts will often become more severe and complex. This may lead to requirements for specialised assessment and treatment of mental and physical ill health (Smith, Humphreys and Wilson, 2008).

Services supporting high risk populations or workplaces are generally not PTSD, Secondary Traumatic Stress and Vicarious Trauma specialists. Most workplaces, where such trauma is a WH&S risk, do not have early intervention practices to identify and manage the impact before it becomes a psychological injury. The Ambulance Service of NSW provides information for staff on "Coping with Trauma" and refers those impacted to an Employment Assistance Program service or the Chaplin. Pre-injury management and referral to a specialist Vicarious Trauma or trauma counsellor is not offered.

The impacts of PTSD, Secondary Traumatic Stress and/or Vicarious Trauma may mean the worker is more likely to:

- Be absent from work more often and for longer periods,
- Suffer both physical and mental health issues,

- Bully or be bullied at work,
- Avoid work or experience work performance issues,
- Self-medicate to manage the symptoms, which may lead to substance abuse, and
- Experience difficult personal and family relationships, and/or resign, or take stress leave, or make a workers' compensation claim for psychological injury.

Workers experiencing PTSD, Secondary Traumatic Stress and/or Vicarious Trauma are less likely to be promoted or participate in team activities.

Workplaces where staff are experiencing unmanaged PTSD, Secondary Traumatic Stress and/or Vicarious Trauma in comparison to other workplaces will have:

- Higher rates of workplace disputation and interpersonal disputation,
- Higher rates of staff turnover,
- Low workplace morale,
- High workers' compensation premiums, and
- Low rates of volunteer participation.

The financial cost to employers of these work related mental injuries is considerable. *"The consensus is that the prevalence of PTSD is underestimated, and that traumatised workers are more likely to take sick leave and to retire early. It is difficult to quantify the actual cost."* (Berger et al. 2010).

Safe Work Australia has estimated that "*the cost to the Australian economy for work related injury and disease is $61.8 billion and the cost of workers' compensation claims for work-related mental disorders to be $480 million."* (Cost of Injury and Illness Statistics, Safe Work Australia, 2017).

The NSW Government Discussion Paper- *Mentally Healthy Workplaces in NSW (2017)* outlines:

- Reporting and underreporting of work related mental ill health,
- The cost of absenteeism to NSW workplaces ($1.5B per annum), and
- The average cost to the community of each work-related disease ($24,800).

Combined, this suggests the financial cost burden associated with work related mental injury is enormous.

## What the Research Tells Us

- Trauma, workplace injury, threat and death is highest for emergency services workers.
- Barriers to seeking assistance include fear of performance reviews, confidentiality, stigma related to mental ill health, and 'macho' work cultures.
- Remote locations further reduce access to support services.

A review of national data in relation to occupational injury risk among Australian paramedics (Maguire, O'Meara, Brightwell, O'Neill, and Fitzgerald, 2014) found that the risk of serious injury for these workers was seven times higher than the national average and the fatality rate for paramedics was six times higher than the national average. The review outlines that ten paramedics are seriously injured each year as a result of assaults. It concludes that the paramedic profession is one of the most dangerous occupations in Australia. These findings correspond with those identified in systematic reviews of world-wide pooled data (Beger et al., 2011), in which paramedics have been identified as having the highest prevalence of PTSD of all types of rescue workers.

A study of professional firefighters in Western Australia found that the rates of exposure to trauma for Department of Fire and Emergency Services workers is significantly higher than the general population. Reports of PTSD symptoms for this group of workers are also high. These findings correspond with the findings of systematic reviews of international literature related to rates of PTSD for firefighters (Skeffington, Rees and Mazzucchelli, 2017).

In a review of literature about work-related PTSD, Skogstad et al., (2013) note variances in reporting of traumatic stress between different groups of workers, emphasising the very high rates of reporting of PTSD amongst:

- Firefighters (20%),
- Ambulance personnel (close to 20%), and
- Health care professionals, mental health care workers, intensive care nurses and train drivers who have been exposed to 'person under strain incidents'.

A number of systematic and in-depth reviews identify that professional and volunteer emergency services workers have a much higher risk of being exposed to traumatic events in the course of their regular work. These and other workers, who are exposed to events that are more likely to be traumatising, also identify a higher than average prevalence of PTSD when compared with the general population. (Berger et al., 2011, Skogstad et al., 2013).

The risk of exposure to repeated trauma and injury, threat and death is higher for emergency services workers and workers grouped in particular industries. (McFarlane, 2007).

Meta analysis of global studies suggest a higher likelihood of exposure to trauma and higher prevalence of PTSD amongst emergency services workers, health care professionals and some other groups of workers. It also suggests that workers who are more likely to be exposed to traumatic events at work are less likely to seek help for psychological problems. Factors associated with less help seeking include:

- Fears related to performance reviews,
- Stigma associated with mental ill-health,
- Fears about confidentiality in accessing support,
- 'Macho' or male-dominated work cultures that stigmatise help seeking as a weakness, and
- A lack of normalisation and promotion of help-seeking behaviours within workplaces

(Berger et al., 2011; Skogstad et al., 2013).

As outlined in the *NSW Mental Health and Wellbeing Strategy for First Responder Organisations in NSW (2016),* volunteer first responders face unique and additional stressors in their work environment. This can exacerbate work-related mental health injuries. Remote locations, differences in levels of training, lack of clear pathways to support services, a lack of infrastructure for acknowledging work-related traumatic stress and expectations related to working in a volunteering capacity can complicate help-seeking.

Recent reviews of work-related PTSD note the heterogeneous nature of occupational groups who are exposed to increased trauma in the course of their work. In relation to factors such as assigned duties, socio-demographic characteristics and frequency of exposure to traumatic events, the different characteristics of these occupational groups is under-researched (Berger et al. 2010). This proposal is offered in the knowledge that vital research is underway in Australia and internationally. The support offered to workers by the proposed 24/7 Telephone Counselling Service will be undertaken with reference to existing professional and accredited guidelines. The project will seek a research partner with a view to ongoing evaluation and research, and incorporation of the findings into the evidence base. Findings will also be used to improve the quality of the service offered.

Diagnostic and treatment guidelines, based on the literature pertaining to PTSD, Secondary Traumatic Stress and Vicarious Trauma, have been developed by large research and expert mental health governing bodies and associations. This proposal is informed by these expert frameworks.

**Barriers to Service Access include:**

- Geographic and time constraints,
- confidentiality,
- self attribution of blame for mental health difficulties, and/or
- capacity of existing providers.

**Geographic and Time Constraints**

Emergency services workers are employed on 24/7 rotating rosters. They can be working in remote or isolated areas where face-to-face services are not available or readily accessible. The nature of emergency services work is that each day can be different and unpredictable and exposure to traumatic events can occur in a random and unpredictable manner. When trauma is experienced, access to services that operate on 'usual hours', or may be located hundreds of kilometres from the worker, may mean those service will not be accessed. This may result in escalation of the trauma impacts. For this reason the proposed Service will operate 24/7.

**Confidentiality**

It is commonly identified that workers hold concerns about employers finding out they are being impacted by the trauma they encounter at work. These concerns relate to perceived or actual consequences for performance reviews, career and pay. This in part explains the low rate of participation in industry programs like EAP. The 24/7 Telephone Counselling Service is proposed to be provided by an NGO and will be funded by the NSW Government. It will be a standalone service that is not contracted by any individual or group of emergency services. Confidentiality as well as being guaranteed will be perceived to be guaranteed.

**Self Attribution of Blame for Mental Health Difficulties**

Research identifies that emergency services workers are reluctant to seek support because of the expectation that the jobs they do require them to be highly resilient and not experience adverse emotional or psychological impacts. Research regularly references the historically "macho" culture present in first responder organisations where admitting what has been perceived to be "weaknesses" has been discouraged. These not unusual perceptions, internalised by workers in jobs that require a high degree of resilience, physical strength and endurance, can lead to workers attributing a level of self blame in relation to the PTSD, Secondary Traumatic Stress or Vicarious Trauma they experience. Self attribution of blame and related difficulties prevent people from being able to normalise the impacts and their need for support.

**Capacity of Existing Providers**

The NSW Government Discussion paper - *Mentally Healthy Workplaces in NSW (2017, p. 18)* identifies that EAP programs are often under-used. Perceptions of poor confidentiality and limited trauma skills of the service providers are often identified as reasons for under utilisation.

In addition, other commonly accessed industry programs like critical incident stress debriefing have been repeatedly shown to have virtually no efficacious outcomes for workers exposed to

potentially traumatising events at work, and can sometimes be detrimental (van Emmerik, A., Kamphuis, J., Hulsbosch, A., & Emmelkamp, P., 2002).

PTSD, Secondary Traumatic Stress and Vicarious Trauma are psychological injuries that require specialist interventions by practitioners who hold the knowledge and skills to assess and therapeutically intervene when a worker experiences work-related traumatic stress. EAP providers, and others such as pastoral care services, utilised by emergency services and others, offer considerable value in more general life experience supports. In submissions to the *NSW Government Inquiry into Emergency Service Agencies*, some of the generalist services themselves identified that they do not hold the skill base to adequately respond to a worker experiencing PTSD, Secondary Traumatic Stress and/or Vicarious Trauma. An inadequate response to a worker experiencing PTSD, Secondary Traumatic Stress and/or Vicarious Trauma has the potential to considerably amplify the impact of the trauma.

## The Proposal - 24/7 Telephone Counselling Service

That a specialist 24/7 telephone trauma counselling service for emergency services workers experiencing PTSD, Secondary Traumatic Stress and Vicarious Trauma be established.

That the Service be provided by Rape & Domestic Violence Services Australia.

That an independent research institute work in collaboration with Rape & Domestic Violence Services Australia to establish an evaluation framework for 24/7 Telephone Counselling Service and identify knowledge gaps and research methodology that will enable:

- The 24/7 Telephone Counselling Service to continue to be evidence-based,
- identify quality improvements, and
- add to the knowledge base in relation to work-induced PTSD, Secondary Traumatic Stress and Vicarious Trauma.

The 24/7 Telephone Counselling Service proposed by Rape & Domestic Violence Services Australia will be:

- Based on an understanding of the need for "Stepped Care", as outlined in *The Australian Government's Mental Health Commission National Review of Mental Health Programmes and Services (2014)*,
- Judith Herman's widely acknowledged *Stage Based Model of Trauma Recovery* (Herman J, 1992),
- *The Transtheoretical Model of Change (TTM)*, widely used and developed by Prochaska and Di Clemente in 1982, and
- will utilise a crisis intervention model based on the work of Roberts, 2005.

The 24/7 Telephone Counselling Service will meet the recommendations of the *Expert Guidelines for Diagnosis and Treatment of Post-Traumatic Stress Disorder in Emergency Services Workers.* It will provide an empathic, resilience-building bridge to ongoing trauma specialised supports when diagnostic and medical interventions are required.

An advisory body will be formed to oversee the establishment, service provision, evaluation and research of 1800TRAUMA. Importantly the body will provide the link between the trauma counselling service and emergency services to ensure service provision is well targeted, culturally appropriate, and operates in accordance with the PTSD, Secondary Traumatic Stress and Vicarious Trauma management goals of the organisations. The advisory body membership will be

representative of the emergency services, Government, researchers and the 24/7 Telephone Counselling Service provider.

The 24/7 Telephone Counselling Service will collaborate with emergency services organisations, mental health specialists and specialist research and mental health institutes, such as the Black Dog Institute. This collaboration will seek to develop robust protocols for referral, service interconnectedness with reference to stepped care, 24/7 Telephone Counselling Service promotion, and ongoing research into work-induced PTSD, Secondary Stress and Vicarious Trauma. The collaboration has the potential to develop information and responses that can be accessed through other communications and to develop Emergency Services' capacity to recognise, understand and respond to this key WH&S issue.

It is the experience of Rape & Domestic Violence Services Australia that callers to telephone services are often in the early stages of help seeking. Most are experiencing trauma symptoms. Commonly these impacts may be not be well understood by the caller. Simultaneously the symptoms can be creating considerable concern. For some, the symptoms and concerns will have progressed to a point of crisis. Crisis intervention, psycho-social education in relation to the impacts, expert assistance as they consider their options, and strategies for symptom management, are common first steps.

It is clear that if a 24/7 expert telephone service were not available, most would not act to alleviate their situation, or symptoms, until matters were considerably more severe. Many talk about considerable barriers to contacting a face-to-face service, or accessing a service where they hold concerns about confidentiality.

A positive and validating experience in accessing telephone-based counselling when people feel overwhelmed, fearful of outcomes, and hesitant about counselling can;

- Reduce and alleviate impacts,
- Increase client confidence and recovery rates, and
- Increase decision-making capacity in relation to accessing ongoing supports.

The proposed 24/7 Telephone Counselling Service will provide trauma-specialised interventions in the areas of:

- Crisis intervention,
- Brief empathic support,
- Strategies to assist in containing overwhelm and acute distress,
- Psycho-education, and

- Referral to ongoing face-to-face supports for workers impacted by work-related PTSD, Secondary Traumatic Street and Vicarious Trauma, where such counselling and support is needed.

This expert telephone intervention will often lead to a considerable reduction in the need for further interventions as the early and specialist intervention can assist the worker to understand and manage their symptoms.

In their PTSD guidelines, approved by the National Health and Medical Research Council (NHMRC), The Phoenix Australia Institute provide the following clear advice:

> *"In the early aftermath of a traumatic event, routine psychological debriefing is not recommended. The best approach to helping people following a potentially traumatic experience is to offer practical and emotional support and encourage the use of helpful coping strategies and social supports. The goal here is to enhance the person's natural resilience and coping ability in the face of trauma" (Phoenix Institute, pg 13).*

The Phoenix Institute recommend, in line with the *National Review of Mental Health Programmes and Services (2015)*, a '*stepped care'* model that recognises that some people will develop extreme stress responses to traumatic events, but not everyone who experiences a traumatic event will develop a diagnosable disorder (Phoenix Institute, pg 13). Their guidelines include recognition that people who experience a traumatic event can develop a range of adverse mental health impacts on a scale from low level, through moderate to an extreme stress response.

A stepped care model that is accessed via a confidential, anonymous, trauma-specialised, crisis intervention telephone counselling service accessible 24 hours a day, would provide the critical support that is not currently available to emergency services workers in NSW. The service may enable symptom management with reduced need for further intervention. The service would also address barriers to engaging in further evidence-based therapeutic support for work-related mental health difficulties when further intervention is needed. This would be a world-first service. It will offer an integrated and responsive approach based on considerable evidence that the early intervention offered by the 24/7 Telephone Counselling Service will substantially reduce the adverse mental health impacts of PTSD, Secondary Stress and/or Vicarious Trauma for emergency services workers.

**Stepped Care Model**

This model describes a continuum of key service elements that are required to most efficiently provide needs-based support to people with (or at risk of) mental illness. It is based on six design principles, which seek to shape a mental health system. They are:

- Person-centredness - mindful of natural supports and is recovery orientated. It aims to deliver a consistent experience no matter the entry point or pathway through the system.
- Effective - the model and service elements are supported by the existing evidence base.
- Flexible - provides for a spectrum of service elements from least to most intensive, in a range of modalities, times and places.
- Efficient - seeks to deliver access to the lowest cost service that will meet each individual's need.
- Timely - facilitates timely access to services both over the life course and within an episode of illness.
- Coordinated - enables and supports coordination and integration of mental health and other services.

Stepped care is defined as an evidence-based, staged system comprising a hierarchy of interventions, from the least to the most intensive, matched to the individual's needs. While there are multiple levels within a stepped care approach, they do not operate in silos, nor is progress one directional. The model offers a spectrum of service interventions tailored to current need.

The 24/7 Telephone Counselling Service will offer an evidenced-based highly accessible service in which the caller can choose to remain anonymous. For many, the 24/7 Telephone Counselling Service will be the first point of entry into counselling and support. Where the emergency service worker is experiencing work-related PTSD, Secondary Traumatic Stress and/or Vicarious Trauma symptoms at the least severe end of the scale, contact with the 24/7 Telephone Counselling Service may be one to three sessions. The work will often focus on psychosocial education to normalise and understand PTSD, Secondary Traumatic Stress and/or Vicarious Trauma and tailored strategies for symptom management. For many, occasional calls throughout their career, at times of trauma, may enable containment and management of symptoms. The outcome may be that the emergency services worker will not move to experiencing the more severe mental health impacts that may lead to a workplace injury and/or workers' compensation claims. The 24/7 Telephone Counselling Service intervention may:

- Have considerable positive outcomes for emergency service workers, including supporting them to continue in their chosen career, and
- in emergency services workplaces, through reduced and/or accepted and managed impacts, decrease environments where behaviours such as bullying occur.

Where more severe PTSD, Secondary Stress and/or Vicarious Trauma impacts are being experienced by the emergency services worker, referral to local services will occur. In making such referrals the 24/7 Telephone Counselling Service will seek to build the emergency services worker's help-seeking capacity and work with the emergency services worker to reduce barriers to accessing

such services. Where the emergency services worker's current state indicates that intensive support may be needed, a clinical care network between the emergency services worker, 24/7 Telephone Counselling Service and the worker's face-to-face supports may be established. This will allow ongoing access to 24/7 telephone counselling that supports the work being undertaken in the face-to-face environment. As the emergency services worker moves toward recovery, the clinical care network will be modified to reflect their decreased reliance on 24/7 telephone support.

This client-centred model will allow the emergency services worker to access the level and intensity of support they need, when they need it, with reference to the current impacts they are experiencing. This will create considerable flexibility and efficiency in the service model. Coordination between the 24/7 Telephone Counselling Service and other services will reduce any duplication of service, while ensuring all of the emergency services workers' needs are being met. The 24/7 Telephone Counselling Service will ensure immediate services are 24/7 accessible with ongoing service provision being well targeted to the emergency service workers current and progressive needs.

**Crisis**

The *Expert Guidelines: Diagnosis and Treatment of Post-Traumatic Stress Disorder in Emergency Services Workers (2015)*, developed by Australian experts, outlines how the nature and pattern of trauma exposure can vary amongst emergency services workers compared to the general population. The guidelines show how this can result in differences in the ways that trauma symptoms present for these workers. One way that workers can present for support regardless of whether their symptoms have accumulated over a period of time in response to exposure to successive trauma, or as an acute response to a particular event, is in a state of crisis. A crisis, broadly defined, occurs when people's usual coping mechanisms and resources are overwhelmed by the emotional, psychological and physiological symptoms they are experiencing.

Rape & Domestic Violence Services Australia has over 45 years experience in crisis intervention work in supporting people impacted by trauma and extreme stress via 24/7 telephone based services.

**Crisis Intervention Model**

The Crisis Intervention model utilised by the 24/7 Telephone Counselling Service will assist in the acute crisis period where there are feelings of dysphoria, disorganisation and disequilibrium. Walker (1987) argued that the first period in a client's recovery is an acute crisis period. During this period crisis intervention strategies are most important where behaviour such as denial and

compliance are framed as strengths in recognition of survival. The counsellor works to assist the client to develop their own plans based on strengths and resources, to be enacted at their own pace (Best Practice Manual for Specialised Sexual Assault Crisis Telephone and Online Counselling, NSW Rape Crisis Centre, 2008, 2014).

Crises are usually considered to be time limited i.e. not exceeding a period of six to eight weeks, before the degree of subjective discomfort has sufficiently subsided to enable an individual to return to a relatively normal level of functioning (Janosik, 1984; Parad & Parad, 1990). However, at times, a crisis can become more enduring and result in a more chronic or long-term state of disequilibrium lasting months or years. James and Gilliand (2001) refer to this chronic condition as a *transcrisis state*.

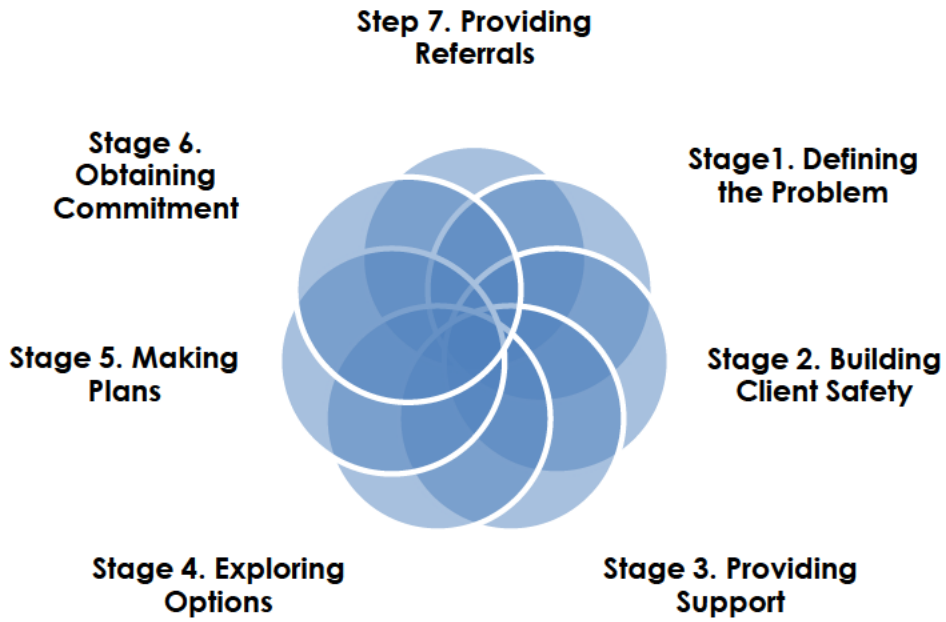
Any model of crisis intervention must be modified to meet the characteristics of individual clients. Factors such as age, gender, ethnicity and cultural diversity will affect both how the individual reacts to different crises and the types of interventions that would be appropriate to use.

24/7 Telephone Counselling Service counsellors will utilise a seven stage crisis intervention model, based on the work of Roberts (2005), and modified by Rape & Domestic Violence Services Australia for use in the telephone environment.

| Stage | Task | Action |
|---|---|---|
| 1 | Defining the problem | The counsellor will engage in a collaborative process with the emergency services worker to determine their perception of the presenting problem. Defining the problem may be a process over time and it may change as the emergency services worker's circumstances change. |
| 2 | Building safety | Determining safety is of the utmost importance. An emergency services worker's safety may be compromised from both external threats (e.g. further threats of violence, continued engagement with the trauma of others) and internal threats (e.g. self-harming ideation, inability to sleep, eat or drink due to impacts). Safety assessment will be a constant focus throughout all interventions. |
| 3 | Providing support | Vulnerability and feeling out of control are dominant characteristics of a client in crisis. The counsellor assists the emergency services worker to move back to a place where psychological equilibrium is present. It is important to empower the worker to be in control of their process of recovery. |
| 4 | Exploring options | The counsellor, with the emergency services worker, will explore options in four areas: human support, cognitive strategies, coping mechanisms, and behaviours. Active listening, reframing, paradoxical questioning, and |

| | | |
|---|---|---|
| | | clarifying questions will assist the emergency services worker to generate their own options. Counsellors may also suggest additional options. |
| 5 | Making plans | Once options are identified, the counsellor, with the emergency services worker, will then move toward an action plan. |
| 6 | Obtaining commitment | This stage calls for the emergency services worker to move from planning, evaluating, and thinking to doing. Motivational interviewing strategies such as creating cognitive dissonance are utilised. (see Miller & Rollnick, 2002) |
| 7 | Providing referrals | Rape & Domestic Violence Services Australia holds an extensive database of NSW services. With client consent, referral may be via warm transfer. |

While crisis is a stepped process back to equilibrium it rarely moves sequentially from stage one to seven. More commonly crisis intervention will be a process where the client moves between the different stages as represented in the following diagram.




While emergency service workers may contact in a state of crisis, once equilibrium has been achieved, the stage of trauma recovery the emergency services worker is experiencing will be assessed and responded to. As emergency services workers move through the stages of recovery they may re-experience crisis. The aim of counselling interventions will be to reduce the incidences and severity of crisis and assist the worker to develop management strategies when crisis occurs.

**Stage Based Model of Trauma Recovery**

Judith Herman's work (Herman, J., 1992) and the Transtheoretical Model (TTM) developed by Prochaska and Di Clemente (1992) provide an understanding of the stages of change and trauma recovery. The models also direct best practice therapeutic supports for each stage of trauma recovery. The model adapts well to working with people who access telephone counselling services in the early stages of help-seeking.

This evidence-based framework provides a fitting underpinning to the NSW Government Discussion Paper – *Mentally Healthy Workplaces in NSW Discussion Paper (2017)* and matches the stepped care approaches recommended in the *National Review of Mental Health Programmes and Services (2015)*.

The 24/7 Telephone Counselling Service practice will be adapted from the stages of change frameworks and modified to accord with recommendations made in the *Expert Guidelines for Diagnosis and Treatment of Post-Traumatic Stress Disorder in Emergency Services Workers*, compiled by expert mental health clinicians and endorsed by the Royal Australian and New Zealand College of Psychiatrists.

In accordance with these recommendations and with the recommendations for Secondary and Tertiary interventions proposed in the *NSW Discussion Paper on Mentally Healthy Workplaces in NSW,* the 24/7 Telephone Counselling Service will target specific interventions focussed at the earliest stages of change and recovery. This will include when people are experiencing crisis.

It should be noted that as per recommendations of most expert organisations in the area of PTSD, the proposed 24/7 Telephone Counselling Service telephone counsellors will not engage callers in structured trauma processing work. Clear recommendations for trauma processing state that such work is to be undertaken in face-to-face counselling. This is because a therapeutic alliance with one therapist, and consistent monitoring of safety, is the primary environment in which the best therapeutic outcome for each client can be achieved.

Of the 15,375 individual clients who contacted Rape & Domestic Violence Services Australia for telephone and online counselling in the 2016/17 financial year, the average number of times they contacted was between one and three. The most common stages in which people contacted was contemplation and preparation for safety. Some contact in the early stages of moving into establishment of safety.

This, in accordance with recommendations in the *Expert Guidelines: Diagnosis and Treatment of Post-Traumatic Stress Disorder in Emergency Services Workers (2015)*, developed by the Black Dog Institute, in collaboration with other PTSD experts in Australia, means that the 24/7 Telephone Counselling Service will adopt the stages of change counselling intervention model.

The model comprises the following key components:

Stage 1: Contemplation and Preparation for Safety

Stage 2: Establishing Safety

Stage 3: Trauma Processing

Stage 4: Connection

**Stage 1: Contemplation and Preparation for Safety:**

In the contemplation stage people are not yet ready to take action to address traumatic stress or other impacts of exposure to trauma. Preparation is the stage in which people intend to take action in the immediate future. Typically, they have already taken some significant action in the past year. These individuals sometimes have a plan of action developing. Most people in this stage of recovery will take multiple forms of action on a daily basis to mitigate the adverse impacts of the trauma they are exposed to and its effects on their lives. They may also experience a range of perceived and real barriers to accessing support. This leads to people feeling restricted in their help-seeking.

Barriers to taking action to access support can also stem from:

- Ambivalence about making changes,
- Misattributions about responsibility for the traumatic stress,
- Self blame,
- A lack of recognition in the workplace that traumatic stress is a normal response to exposure to trauma,
- Lack of a clearly identified confidential and easily accessible pathway to support, and
- A workplace culture that consciously or unconsciously shifts blame for the experience of adverse mental health responses onto the worker or volunteer.

Whilst people in these stages may not yet be ready to take action, or may be preparing to take action to address trauma or other adverse impacts, they often contact counselling services for assistance to accurately conceptualise their problems, evaluate the good versus the bad of taking action and gather information about possible courses of action and supports available to them.

**Counselling Strategies for use in the Contemplation and Preparation for Safety Stage:**

- Thoroughly assess safety risks and develop safety plans where necessary, in relation to risk of harm to self or others
- Assessment of the presenting problem/s and what a client wants
- Provide psychoeducation about causes and consequences of work related PTSD, Secondary Stress and Vicarious Trauma and related impacts, to normalise and destigmatise those impacts
- Crisis intervention
- Raise motivation for recovery from trauma and related impacts
- Problem-solve barriers to taking action to access support or perceived insurmountable tasks

- Address experiences of overwhelm using psychological and trauma-informed strategies. Such strategies may include focus on assisting in the reduction of physical arousal and symptoms of extreme physical, psychological or emotional overwhelm
- Emotion regulation
- Identifying strengths and resilience
- Providing psychoeducation about self-care and strategies that may assist in regulating emotional, psychological and/or central nervous system overwhelm or difficulties
- Provide information about and referral to available supports

**Establishing Safety:**

The experience of Rape & Domestic Violence Services Australia in working with survivors of sexual assault and domestic violence is that people contact the service between one to three times after moving into action and beyond the contemplation and preparation stages. Often this is for building emotional and psychological safety or actual physical safety once decisions have been made to make changes and access support. It is envisaged that emergency services workers or volunteers may follow similar paths.

Sometimes there is a gap between when people first call a telephone counselling service and when they are able to obtain a first appointment with a face-to-face counsellor. Appropriately, they may re-contact the 24/7 Telephone Counselling Service to maintain momentum in help-seeking and stabilisation during this waiting period.

The 24/7 Telephone Counselling Service will offer brief interventions to assist in containing and reducing distress or symptom overwhelm during these short periods and build on counselling strategies offered in the contemplation and preparation stages.

**Counselling Strategies used in the Establishing Safety Stage:**

- Conduct ongoing safety assessments
- Provide and reinforce information on available supports and link to local services and therapists
- Crisis intervention
- Reinforce psychoeducation about causes and consequences of work related PTSD, Secondary Stress and/or Vicarious Trauma, to normalise and destigmatise
- Build self efficacy and sense of autonomy and control
- Problem-solve barriers to accessing supports
- Assistance to manage trauma symptoms
- Provide skills and training for emotion regulation and self-care
- Reinforce strengths, resilience and problem-solving capacities
- Symptom management strategies

**Trauma Processing:**

This work engages with the memories of traumatic events. Structure and planning is therefore required. It is widely recommended that this work be undertaken with a face-to-face counsellor. There is some debate about whether or not it is necessary for people to engage in trauma processing once they have achieved significant reduction in trauma symptoms or related impacts from exposure to trauma. Some level of trauma processing can take place in earlier stages of help-seeking and recovery because trauma processing is related to making meaning of traumatising experiences that can involve grieving, mourning and other emotional processing. The proposed 24/7 Telephone Counselling Service, in accordance with therapeutic guidelines for working with PTSD, will not facilitate in-depth trauma processing in telephone counselling sessions. Counsellors will take a great deal of care to provide callers with psychoeducation about why this is the case. The 24/7 Telephone Counselling Service counsellors will engage with emergency services workers about why referrals to one face-to-face trauma specialised therapist are required for this work.

In cases where accessing a trauma specialist face-to-face is not possible due to geographical barriers, limited therapist availability, including in rural areas where the emergency services worker may have other connections with the only therapist available, or where other significant barriers are present, the 24/7 Telephone Counselling Service would negotiate a client-centred solution with the caller, utilising supports that may be available.

**Connection:**

Connection work is thought to commence when clients find that their trauma impact symptoms are largely under control (Herman, 1997). This work is usually undertaken in face-to-face counselling in which a therapeutic alliance has been developed with one counsellor. It is a reflective stage where clients may begin to acknowledge aspects of their lives that provide a sense of meaning, positive social engagement and fulfilment. The therapeutic goals in this stage might focus on:

- developing a positive and manageable engagement or re-engagement in employment or volunteering,
- building or re-building relationships,
- exploring what might construe a sense of broader meaning in life for the emergency services worker, and
- how to engage in activities that produce a sense of enjoyment, purpose and wellbeing.

At Rape & Domestic Violence Services Australia, the experience of working with survivors of sexual assault and domestic violence is that a small number of people make contact when in this stage. This is mostly because this work is undertaken in face-to-face counselling. However, sometimes people contact after face-to-face counselling has concluded, wanting to engage in this reflective process. This may relate to a challenge they are facing once they have recovered from significant

trauma or related impacts. These calls are usually one-off events and can be facilitated by the 24/7 Telephone Counselling Service trauma specialised counsellors.

**Other Matters for the 24/7 Telephone Counselling Service**

While the 24/7 Telephone Counselling Service interventions with emergency services workers will be based on the Stepped Care Models, Judith Herman's Stage-Based Model of Trauma Recovery, the Transtheoretical Model of Change and Crisis Intervention, the impacts of PTSD, Secondary Traumatic Stress and/or Vicarious Trauma will ensure that at times 1800TRAUMA will need to manage risk of harm to self or others.

**Risk of Harm to Self and Others**

While confidentiality is a critical element of any counselling service where there is a risk of harm to self or others, the 24/7 Telephone Counselling Service counsellors will hold a duty of care responsibility that supersedes their ethical requirement of confidentiality.

**Suicidality**

Between 2000 and 2010 emergency services workers are known to have completed suicide in Australia, indicating the seriousness with which risk of harm must be acknowledged, assessed and managed by professionals supporting emergency services workers.

According to multiple models of crisis intervention and trauma therapy, building client safety is an essential stage of crisis intervention that must be achieved before recovery from trauma can be realised (Herman, 1992; Roberts, 1991; Kezelman & Stavropoulos, 2012). Rape & Domestic Violence Services Australia has decades of experience supporting people through crisis and when they might be at risk of harming themselves or others, or at risk of harm from others because they are internally (emotionally, psychologically), or externally, unsafe.

In acute crisis, a client may not be able to maintain their own safety due to impairments in decision-making, problem-solving and self-care. The 24/7 Telephone Counselling Service will be guided by the ethical practice frameworks published by the Australian Psychological Society (APS), the Australian Association of Social Workers (AASW), and Counsellors and Psychotherapists Association of NSW (CAPA), in relation to assessing the risk of harm to clients, in view of issues pertaining to client confidentiality.

Risk assessment has always been a core component of the work undertaken by specialised trauma counsellors at Rape & Domestic Violence Services Australia. Trauma specialist counsellors are highly trained in risk assessment in relation to risk of harm to self or others. Frameworks used are internationally recognised best practice models.

A number of factors associated with increased risk of suicide have been identified in the professional literature. These risk factors include:

- At risk mental status (e.g., depression, hopelessness, despair, agitation, shame, guilt, anger psychosis or psychotic thought processes)
- Recent interpersonal crisis, especially rejection or humiliation
- A recent suicide attempt
- Recent major loss, trauma or anniversary
- Intoxication or withdrawal from alcohol or other drugs
- Financial difficulties or unemployment
- Impending legal prosecution or child custody issues
- Cultural or religious conflicts
- Lack of a social support network
- Unwillingness to accept help
- Difficulty accessing help due to lack of information, lack of support or negative experiences with mental health services prior to immigration
- Hopelessness

Hopelessness is one of the main factors mediating the relationship between depression and suicidal intent. Some people experiencing hopelessness may conclude that death is a better alternative than living a life in which they believe there is no hope for a positive future. (NSW Department of Health, 2004).

Hoff (1989) provides a useful summary of typical indicators and the corresponding risk category. The risk categories assist decision-making in determining the intervention required.

| Risk Category | Typical Indicators |
|---|---|
| No predictable risk of imminent suicide | Has no notion of suicide or history of attempts. Has satisfactory social support networks and is in close contact with significant others. |
| Low risk of imminent suicide | Has considered suicide with low lethal method. No history of attempts or recent serious loss. Has satisfactory support network. No alcohol or drug problems. Evidence of future orientation. |
| Moderate risk of imminent suicide | Has considered suicide with highly lethal method but no specific plan or threats, or has plan with low lethal method. History of low lethal attempts, with tumultuous family history and reliance on medication for stress relief. Is weighing the odds between life and death. |
| High risk of imminent suicide | Has current highly lethal plan, obtainable means, and history of previous attempts. Has a close friend/relative but is unable to communicate with them. Has a drug and/or alcohol problem. Is depressed and wants to die. |

| | |
|---|---|
| Very high risk of imminent suicide | Has current highly lethal plan with available means, history of highly lethal suicide attempts and is cut off from social supports and resources. Is depressed and uses alcohol/drugs to excess, and is threatened with a serious loss, such as unemployment, divorce or school failure. |

Where a risk of suicide has been identified the 24/7 Telephone Counselling Service counsellors will work in collaboration with the emergency services worker to establish a safety plan. The plan will include steps the emergency services worker can take to stay safe. These steps centre on the worker actioning the following:

- Keeping their home environment safe (e.g., removing firearms), recognising warning signs that a suicidal crisis may be approaching,
- Coming up with ways to cope personally with suicidal thoughts, without calling on other people or resources,
- Identifying friends, family, and other people to contact for help or distraction, and
- If that doesn't reduce the risk, identifying mental health agencies and other places (e.g. a hospital emergency room) that the emergency services worker can call or visit.

If the emergency services worker does not exhibit a sufficient shift in suicidal intent, and remains at high risk of suicide, emergency services will be activated. Where collaboration in this activation will not escalate the situation the 24/7 Telephone Counselling Service counsellors will work with the emergency services worker to access and engage with such services.

**Risk of Harm to Self**

People engage in self-harming behaviours for a range of reasons, although they may not necessarily realise why. Self-harm is often a response to feelings of extreme psychological distress or emotional pain. It may provide short-term relief from feelings, creating a sense of control. However, self-harm does not resolve the feelings and the behaviour can become a compulsive and dangerous activity.

While people who self-harm may not intend to end their lives, the consequences of this risky behaviour can be fatal. Such behaviours, therefore, need careful assessment and care. The key aspects in effectively assessing self-harm risk are similar to those in assessing suicide risk:

1. Self-harm ideation and level of intent
2. Self-harm history
3. Current self harm plans - what, where and when
4. Availability of means
5. Lethality of means

The 24/7 Telephone Counselling Service counsellor will determine the lethality of the intended means and therefore risk of fatality. Table 3 lists common self-harming means in risk categories and their potential for fatality.

| **Self Harming Means** | | |
|---|---|---|
| **Low Risk** | **Medium Risk** | **High Risk** |
| • Superficial cutting of arms, legs, torso with clean blade<br>• Superficial burns arms, legs, torso<br>• Regular bouts of binge eating<br>• Hitting parts of the body resulting in minor bruising | • Misuse of non-lethal medication, likely to cause damage to functioning (e.g. kidney damage)<br>• Regular purging or fasting<br>• Regular alcohol abuse, likely to lead to impaired functioning (e.g. liver or brain damage)<br>• Deep cuts in fleshy areas of body (e.g. arms, legs), potential for significant blood loss or infection<br>• Hitting part of the body including head resulting in significant bruising | • Driving whilst intoxicated<br>• Ingesting caustic substances<br>• Burns with flammable liquids (e.g. lighter fluid or petrol)<br>• Lethal or large doses of medication especially with alcohol<br>• Deep cuts, in areas with large blood vessels (e.g. close to wrists)<br>• Head hitting that results in loss of consciousness and/or bleeding, potential for broken bones and brain injury |

Table 3. Lethality Risks of Common Self-Harming Methods.

The 24/7 Telephone Counselling Service counsellors will engage in safety planning with emergency services workers with reference to the strategies recommended by Hoff (1989):

- Relief from isolation e.g. accessing immediate supports
- Removal of lethal weapons e.g., client must dispose of lethal means, or have potentially lethal medications managed by another person
- Encouragement of alternative expression of emotions e.g. use of physical activity, or counselling
- Avoiding any life changing decision-making during crisis e.g. decision to make suicide attempt, quit job
- Rebuilding social networks e.g. scheduling regular social contacts
- Relief from extreme anxiety and sleep loss e.g. relaxation strategies

Figure 5 provides a summary of the steps that will be taken in the assessment and management of risk of suicide or self-harm.

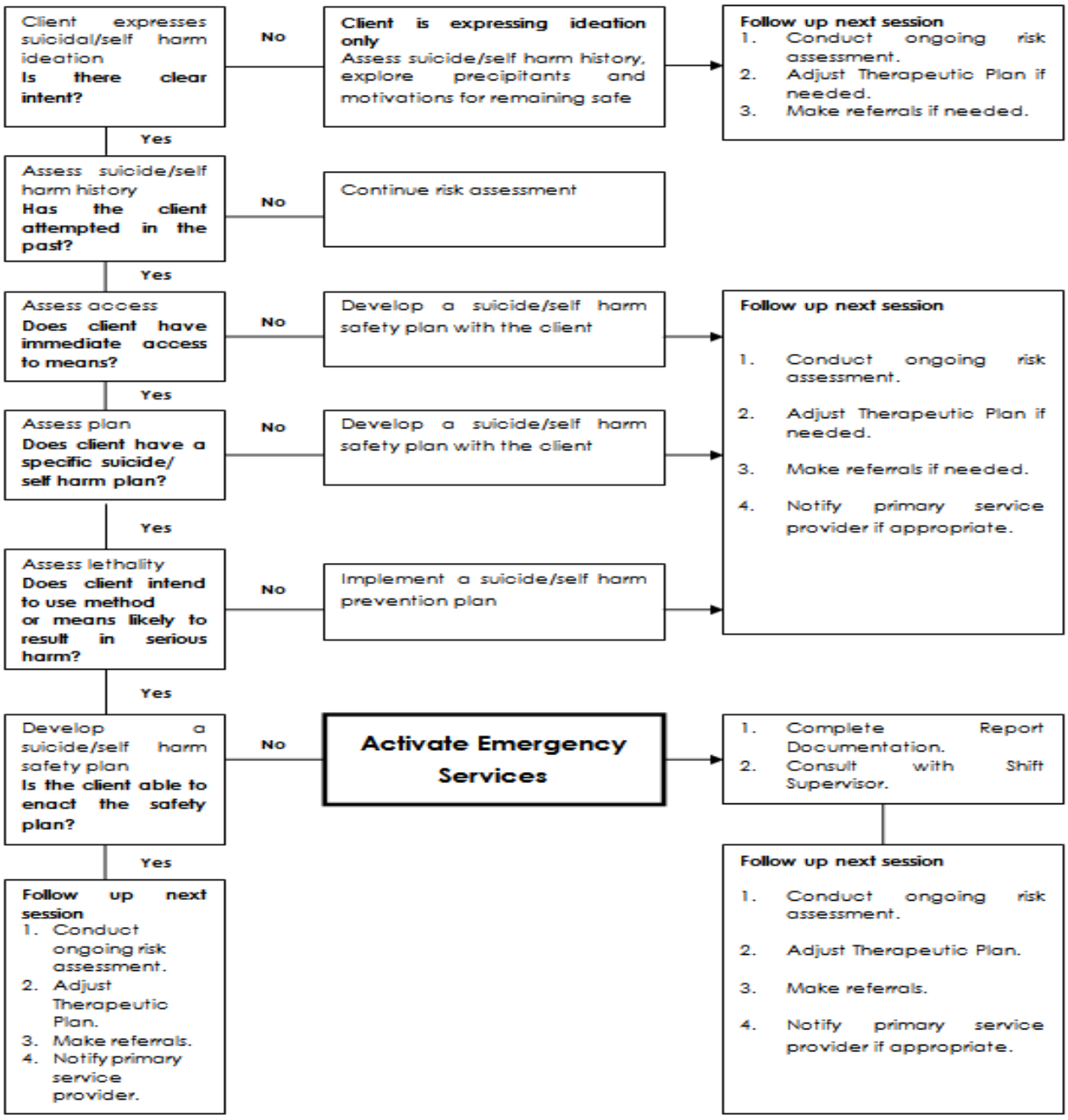



*Figure 5.* Assessment and Management Steps for Client Reporting Indicators of Risk of Harm to Self (Suicide and Self-Harm)

**Risk of Harm to Others**

At times, rather than posing a risk to themselves, emergency services workers may present a risk to others. This may be expressed by the emergency services worker as threatening to harm or kill another person.

In such circumstances the 24/7 Telephone Counselling Service counsellors have a duty of care to the emergency services worker and an ethical responsibility to protect any third parties who are may be harmed.

**A Person-Centred Approach to Recovery**

Rape & Domestic Violence Services Australia, in line with internationally recognised best practice frameworks and recommendations in the *National Review of Mental Health Programmes and Services* (2014) uses a person-centred approach to recovery. A person-centred approach to supporting people with mental health or other bio-psycho-social difficulties is an approach to support that is organised around the needs of people, rather than people having to organise themselves around a system. A 24/7 telephone based service can provide a person-centred introduction to trauma recovery and recovery from adverse impacts of exposure to trauma in the workplace. It is a service that meets people where they are at, at the time the service is needed. Emergency services workers can access the service regardless of their geographical location, at a time that is best suited to their situation, in a space that is confidential and safe, anonymously, and with a high level of control over the intervention.

**Support for Family and Friends**

Friends and family may contact on behalf of those they care about. It may be that the person they are ringing about has approached them as their trusted confidant or that the caller is concerned about what may be happening and is requesting assistance.

Counsellors will work with the caller to assist them to manage the impacts on them. They will also work with the caller to develop a plan for providing support and assistance to the person the caller is ringing about. This may include information about the causes, consequences and impacts of PTSD, Secondary Traumatic Stress and Vicarious Trauma. It may also include connecting the caller to other support services.

For some callers they may have their own trauma histories. This may mean becoming the trusted confidant has re-triggered difficult memories. Counsellors will provide appropriate trauma counselling interventions to assist the caller to manage the impacts.

**Supporting Emergency Services Leaders to Support their Workforces**

In the first instance the 24/7 Telephone Counselling Service will provide face-to-face training to emergency services leaders in PTSD, Secondary Traumatic Stress and Vicarious Trauma. The training will include causes and impacts and how to supervise impacted workers. The training will include creating a workplace where such impacts are accepted as inevitable and that with appropriate early intervention and management injury can be avoided.

At times leaders will experience challenges in supervising or supporting a staff member who may be impacted by PTSD, Secondary Traumatic Stress and Vicarious Trauma. The 24/7 Telephone Counselling Service will assist the leader through specifically tailored interventions based on the specific circumstances as presented by that leader.

**Culturally Sensitive Service Provision**

Rape & Domestic Violence Services Australia applies a number of strategies to assist in making the service culturally sensitive, accessible and appropriate. The main strategy is that the organisation holds the client as the cultural expert. This means that the counsellor is open to learning new ways of working therapeutically and they are guided by the cultural needs articulated by the client.

Other strategies to increase counsellors' cultural sensitivity and appropriateness are:

- Regularly providing counsellors with cross-cultural counselling and skill development training
- Telephone interpreter services usage
- Avoiding making assumptions about the client's sexual orientation and using gender neutral pronouns
- Provision of web-based counselling to speech and hearing impaired clients
- Collaborating with agencies who work with culturally and linguistically diverse people
- Employing counsellors from CALD backgrounds
- Provision of a holistic counselling framework
- Incorporating an acknowledgement of different client values
- Employing a counselling framework that promotes cultural empowerment
- Gathering regular feedback from community representatives on policy and procedures
- Modelling anti-discrimination practices to clients
- Seeking advice from professional and community representatives who hold knowledge on specific culturally bound clinical issues

In preparation for the 24/7 Telephone Counselling Service Rape & Domestic Violence Services Australia staff will engage with emergency service providers in metropolitan, regional and rural areas at senior and middle management, and frontline levels to understand culture and practices. This information will assist in developing tailored counselling interventions that respond to the specific needs of callers. Rape & Domestic Violence Services Australia will be guided by emergency services in this exploratory stage. Once established Rape & Domestic Violence Services Australia will seek to hold annual interaction days with emergency services where counsellors, new to the service, can meet emergency services workers in their workplaces. This will enhance orientation sessions that will be provided by emergency services workers. It will also allow emergency services workers to meet and interact with 24/7 Telephone Counselling Service counsellors in a non-

threatening environment potentially leading to an increase in decision-making to contact the service when work-related trauma impacts are being experienced.

The 24/7 Telephone Counselling Service will engage with the advisory body on the most effective and appropriate way to meet these requirements.

## 24/7 Telephone Counselling Service Establishment Timeframe

It is proposed that the following roll out of the service be considered:

| Step | Tasks | Timeframe |
|---|---|---|
| Decision | In line with the recommendations of the Inquiry into Emergency Services Agencies provider is contracted to provide the 24/7 Telephone Counselling Service. | 2 months |
| Advisory Body | Establish an advisory body to oversee the 24/7 Telephone Counselling Service project. The body is to be representative of government, emergency services, the research body and representatives of the 24/7 Telephone Counselling Service. | 1st 3 months |
| Consultation | The 24/7 Telephone Counselling Service will consult with emergency services and emergency services workers across NSW to understand the culture, current understanding and practices in relation to work-induced PTSD, Secondary Traumatic Stress and Vicarious Trauma. This knowledge will be incorporated into existing clinical knowledge, to ensure the counselling service provided is tailored and appropriate. | |
| Research | In consultation with the NSW Government and emergency services negotiate with a suitable research body e.g. The Black Dog Institute. This research body, in consultation with the 24/7 Telephone Counselling Service provider, will establish the evaluation processes. The collaboration will also establish the research questions and methodology that the 24/7 Telephone Counselling Service may be able to answer, thereby adding to the knowledge base in relation to work-based PTSD, Secondary Stress and Vicarious Trauma. | |
| Establish the 24/7 Service | Staff are recruited and trained in the tailored 24/7 Telephone Counselling Service counselling guidelines. This will include presentations from emergency services and visits by counsellors to emergency services workplaces. | |
| Training | Make available e-training on PTSD, Secondary Stress and Vicarious Trauma to all emergency workers. Note: Rape & Domestic Violence Services Australia has an e-learning option for Vicarious Trauma. This program would be expanded to include PTSD and Secondary Stress and be tailored to the emergency services work | Months 3 to 6 |

| | | |
|---|---|---|
| | environment and culture.<br>Provide training to all emergency services leaders on:<br>• Creating a workplace culture that accepts the inevitability of workers experiencing PTSD, Secondary Traumatic Stress, and Vicarious Trauma,<br>• That it does not need to become an injury, and<br>• How to supervise and support an impacted staff member. | |
| Promotion of Service | In consultation with emergency services develop promotional and ongoing communications that will assist in the acceptance of PTSD, Secondary Traumatic Stress and Vicarious Trauma in emergency services workplaces. The communication will be part of the strategy to create an environment where staff will be proactive in managing their symptoms through self-care and accessing the 24/7 Telephone Counselling Service. | |
| The 24/7 Telephone Counselling Service is made available to emergency services workers. | | Month 4 |
| Evaluation | Agreed quarterly reports on the 24/7 Telephone Counselling Service provided to government, emergency services and to emergency services workers, through agreed communication channels | Ongoing |
| Research | Agreed research activities reported on with reference to established methodology. Papers and other reports will be provided nationally and internationally to add to the national and international knowledge base. | |

## Rape & Domestic Violence Services Australia is Best Positioned and Experienced to Provide the 24/7 Telephone Counselling Service

Rape & Domestic Violence Services Australia has been providing trauma telephone counselling services for 45 years to those in NSW who have experienced sexual assault, domestic and family violence. The organisation is an Incorporated Association and is governed by a Board of 12 women who are elected annually.

**Rape & Domestic Violence Services Australia:**

- has been providing 24/7 telephone counselling for 45 years to those who are experiencing PTSD and complex trauma, as a result of sexual assault, domestic and family violence for,
- currently employs four-year tertiary qualified and highly skilled trauma counselling specialists,
- has researched, written and implemented an evidence-based counselling manual to direct and guide practitioners in their counselling work,
- evaluates its work using process and outcome methodology,
- won the 2007 Workcover NSW award for the 'Best Response to an Identified WH&S Issue', being the organisation's Vicarious Trauma management program,
- utilises a social enterprise model to provide Vicarious Trauma training and management services across Australia,
- partnered with the Country Women's Association to provide training to providers, including emergency services workers in rural NSW, in relation to first response practices and Vicarious Trauma management,
- has developed a tailored client database that enables easy storage and retrieval of files, provides high levels of data security, and capacity to provide non-identifying reports for accountability, reporting, evaluation, research and review purposes,
- has IT redundancy and business continuity procedures in place to offer a high degree of reliability resulting in less than 0.01% down time in the past five years,
- is accredited under the QIP Accreditation program,
- is internationally recognised by the United Nations, in England's service sector and by the All Chinese Women's Federation as an expert in trauma counselling,
- won the Best Poster Award at the 2015 International Society for the Study of Trauma and Dissociation 33rd International Conference in San Francisco for its work on *Assessing and Treating Cognitive and Mood Distortions in Survivors of Sexual Assault According to DSM 5*,
- established the Aboriginal Women's Sexual Assault Network in NSW,
- has an extensive knowledge of national and international evidence of best practice, when working with traumatised populations,

- has sophisticated systems for identification and action where there is a duty of care to a client, their dependents, or others,
- has an active research unit, which maintains, through a cycle of review, the counselling service's evidence base, and
- has governance, human resource, financial, procurement, policy, risk, administrative and compliance policies and practices in place to allow efficient expansion and management of the proposed service.

**Current Services**

| Program | Service offered | Funded by |
|---|---|---|
| NSW Rape Crisis Centre | 24/7 telephone and online specialist trauma counselling for anyone in NSW whose life has been impacted by sexual violence. | NSW Health |
| Community Based Counselling | Face-to-face counselling from NSW Women's Health Centres for women who experienced sexual assault in childhood. | NSW Health |
| Sexual Assault Counselling Service | 24/7 telephone specialist trauma counselling for anyone in Australia who has been impacted by the Royal Commission into Institutional Responses to Childhood Sexual Abuse. | Department of Social Services |
| | Counselling for incarcerated witnesses to the Royal Commission into Institutional Responses to Childhood Sexual Abuse. | |
| Yarrow Place | Out of hours telephone counselling and activation of forensic and other services for the South Australia statewide sexual assault service. | South Australian Dept of Health |
| CBA Project | Telephone counselling and financial support for CBA customers who are escaping domestic violence. | Commonwealth Bank of Australia |
| Behaviour Change Counselling | For men who have, or fear they may, use violence in their relationships. | Large employer of men |
| Queensland Police | Telephone counselling and referral for those who have interacted with police as a result of domestic violence. | Queensland Police |
| Training | Clinical and prevention programs. | Fee for service |
| Supervision | Clinical supervision for staff in other services. | Fee for service |
| Various Trauma tailored solutions. | | Fee for service |
| Domestic Violence workplace policies and training. | | Fee for service |

In 2009 Rape & Domestic Violence Services Australia established the Community Based Counselling Service, which bases counsellors in Women's Health Centre's across NSW. The counsellors work with those who experienced sexual assault in childhood. The location of these services in regional Centres such as Albury, Lismore and Bathurst has embedded networks and knowledge of issues for rural and regional workers into the day to day practice of Rape & Domestic Violence Services Australia.

In 2010, Rape & Domestic Violence Services Australia became the clinical service provider of 1800RESPECT. Until 2017 the organisation delivered this 24/7 national telephone and online counselling service for anyone in Australia whose life has been impacted by sexual assault and/or domestic or family violence. As a result of this national focus the service has built enduring positive relationships with services across the country.

In 2012. Rape & Domestic Violence Services Australia began providing secondary prevention counselling to men who have, or who fear they may, use violence in their relationships. And in 2013, Rape & Domestic Violence Services Australia commenced delivering a national telephone and face-to-face counselling service for anyone impacted by the Royal Commission into Institutional Responses to Child Sexual Abuse.

In 2014, the organisation partnered with the Country Women's Association to provide training in 17 locations across NSW. The training included Responding with Compassion, Prevention, and Vicarious Trauma Management. Attendees included considerable representation form emergency services workers.

As a result of training, service provision and interagency activities, Rape & Domestic Violence Services Australia regularly travels to locations throughout NSW. In part, this work increases the organisation's capacity to understand and incorporate into service provisions the specific issues and concerns of regional and rural people in NSW. In addition, the organisation's current Director of Counselling Services, in her prior position, managed mental health services in Central Western NSW. Her employment by Rape & Domestic Violence Services Australia brings rural knowledge and expertise to a city-based service.

**Key Approaches to Trauma Specialist Counselling**

Counselling services offered by Rape & Domestic Violence Services Australia became trauma-informed and then trauma-specialist in the 1990s in response to Judith Herman's foundational work *"Trauma and Recovery" (1992)*.

The key approaches are:

- service interventions are evidencebased and clinically appropriate,
- staff hold tertiary qualifications and are experienced,

- the organisation provides detailed clinical guidance on:
  - incorporating empowerment, safety and assessment in counselling interventions,
  - supporting those who are experiencing acute and/or psychological crisis,
  - identifying the client's stage of trauma recovery and application of appropriate therapeutic intervention/s,
  - supporting professionals who are experiencing vicarious trauma, and
  - provision of the service from a holistic perspective.
- orientation develops staff skills to that of Trauma Specialist, and training is ongoing through supervision, in-service training, and professional development,
- staff participate in professional and regular trauma-specialist clinical supervision,
  - the organistion offers staff a comprehensive Vicarious Trauma management program,
- process and outcome evaluation informs practice development, in-service training, professional development and clinical supervision, and
- duty of care is well understood and processes are in place to ensure compliance and protection of people made vulnerable by trauma.

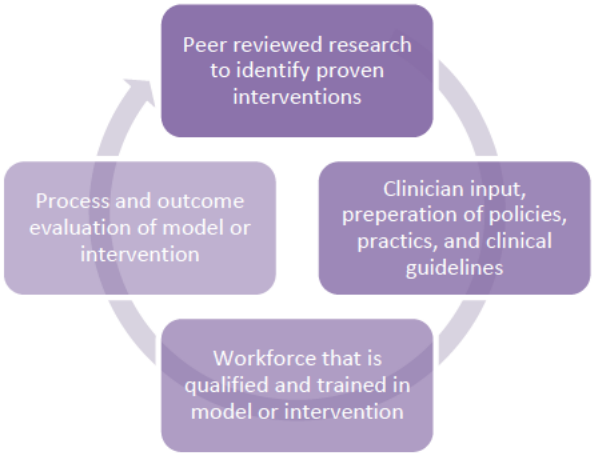
**Evidenced-Based Practice**

Rape & Domestic Violence Services Australia is focused on providing evidence-based interventions to clients. An evidence-based practice involves two key aspects:

1. Counselling interventions must have demonstrated their efficacy in treating the presenting issues they are applied to. This may mean that the interventions have demonstrated their effectiveness in randomised controlled clinical studies. However, as certain counselling approaches are subjected to systematic empirical testing more than others, the data is not equally available for all interventions. *'The range of issues that traumatised clients seek assistance for are remarkably broad so effective response to these issues requires flexibility and diversity (Herman, 2008)*'. Many interventions prove useful to clients struggling to overcome the impacts of trauma. The organisation therefore recognises the need for both evidence-based practice and practice-based evidence.

2. Evaluating the degree to which the counselling provided is effective in producing the desired outcomes for clients.

For Rape & Domestic Violence Services Australia, evidence-based practice is a cyclic process of research, with practitioner input in the development of practice guidelines, staff training, practice model implementation, evaluation and further research, to continue to inform the evidence-based cycle represented as follows:




**Clinical Guidelines**

Rape & Domestic Violence Services Australia follows the guidelines set out by the Australian Centre for Posttraumatic Mental Health (2013) in providing counselling services for people who have experienced, or are experiencing recent trauma. Rape & Domestic Violence Services Australia recognises that in the area of work-related traumatic stress, the Expert Guidelines developed in Australia by the Black Dog Institute, in collaboration with other PTSD experts, provide world-leading direction in the diagnosis and treatment of work-related PTSD. These guidelines will form the critical basis on which the counselling interventions provided by 24/7 Telephone Counselling Service will be provided.

Important clinical guidelines that Rape & Domestic Violence Services Australia adheres to when working with people who have experienced trauma include:

- prioritise the client's external safety (i.e. safety from further traumatisation),
- prioritise the client's internal safety, by ensuring that the client has adequate ability to tolerate distress, soothe the self and regulate their emotions, before attending to processing the traumatic events. Achieving this will often include regularly revisiting and strengthening coping capacities,
- the therapeutic recovery process can take many forms, but should respond to the client's needs who must be in control of their process of recovery,
- understand that the symptoms arising from trauma are mostly adaptive responses to a maladaptive event and/or context,
- work to keep the client connected to themselves and other supports in their communities through grounding strategies,
- provide psycho-education to help clients make meaning of their distress,
- therapeutic work must align with the client's stage of recovery using stages of trauma modality
- at all times convey empathy and uphold ethical boundaries appropriately,

- therapeutic plans must be tailored to a client's needs, to assist recovery and help determine goals, whilst maintaining consistency in a team-based telephone counselling service,
- referral processes and advocacy are provided for immediate and/or practical needs and recovery, and
- all client records are maintained in a secure client database.

**Staff**

All counsellors must hold a four year degree in social work or psychology, or equivalent, and have at least three years counselling experience to be eligible to apply for a position with the organisation. Qualifications and experience are verified through the counsellor's professional association, the awarding tertiary institution, and their previous employers.

Clinical Supervisors must hold the same qualification, have at least five years counselling experience, have provided supervision to practitioners, and have completed further studies in supervision, or be willing to undertake those studies.

The Director of Counselling Services holds a Doctorate of Psychologyl (Clinical) and has 20 years experience, including 15 of those years working in mental health in rural NSW.

Clinical supervision is provided every four weeks to each counsellor. All counsellors participate in quality assurance, in-service training, and professional development.

All non-clinical staff hold qualifications and experience relevant to their position.

All staff complete a criminal record check upon employment and this check is re-applied every two years.

**Quality Assurance**

Rape & Domestic Violence Services Australia has detailed quality assurance practices in place to ensure the evidence-based clinical guidelines inform and direct clinical practice and that positive outcomes for clients are achieved. This includes regular performance monitoring and appraisal of all clinical staff against clinical guideline criteria. Where work of excellence is identified, a review is undertaken to ensure such excellence is maintained and developed. Where quality improvements are identified, these may be addressed in individual supervision, through in-service training or by assisting practitioners to access external professional development.

**The Rape & Domestic Violence Services Australia Vicarious Trauma Management Model**

Rape & Domestic Violence Services Australia recognises that its primary WH&S issue is Vicarious Trauma. Vicarious Trauma is the impact on staff of hearing trauma stories. Given Vicarious Trauma is a workplace injury, the organisation utilises the WH&S hierarchy of control in managing this risk. By using this WH&S hierarchy, the organisation is able to manage the risk base on mutual responsibility between the employer and the employee.

In the first instance, the organisation is clear that all workers will be impacted by the work that the organisation does. The organisation also recognises that staff choose to work in this environment and that there are considerable personal benefits and satisfactions inherent in the work. The aim of managing this impact is to insure the impact does not progress to an injury.

The Vicarious Trauma management actions are:

| WH&S Controls | Actions |
|---|---|
| Education | Vicarious Trauma training provided for all staff in orientation – what Vicarious Trauma is and isn't, symptoms and management. |
| Reduce risk | End of shift handover – leave work at work. |
| Monitor symptoms | Psychometric measures upon employment and then six monthly to measure change. |
| Early intervention | Vicarious Trauma self-monitoring and monitored by shift supervisors. Vicarious Trauma is always a topic in monthly supervision. |
| Promote wellness/ offset symptoms | Use psychometric measures to identify changes, respond with evidence-based self care plans. Offsets fall into three categories, diet and exercise, creative pursuits, and somatic therapies. For cogitative change impacts staff are supported to access counselling external to the organisation. |

For NSW Government services, where exposure to Vicarious Trauma is a risk, Rape & Domestic Violence Services Australia can engage collaboratively with each body to tailor a management program designed for their specific needs and structure. This may include *Train the Trainer* and supervisor training with quality assurance and monitoring by Rape & Domestic Violence Services Australia. Where psychometric measuring is undertaken, analysis and reporting can be completed by Rape & Domestic Violence Services Australia.

**Counselling Service Not a Hotline/Call Centre**

The Rape & Domestic Violence Services Australia counselling service operates in accordance with international best practice standards for clinical work and processes.

| Contact | Rape & Domestic Violence Services Australia Response | Hotline/Call Centre Response |
|---|---|---|
| 1st contact | Therapeutic response appropriate to the client's presenting issue/s and stage of trauma recovery provided. Client consent information is recorded in an intake sheet and a file note of the counselling intervention is recorded by the counsellor at the conclusion of the call. | Generally an information and referral response. Call statistics and limited notes, often a drop down selection, recorded while call in progress. |
| 2nd to 5th contact | Counsellor will review the file note from the previous call/s and provide a therapeutic response that seeks to build on the work of the previous counselling intervention. | As above, with no reference to the previous call/s. |
| 6th contact | The counsellor will engage the client in discussions about their therapeutic goals and, with the client, develop a therapeutic plan for the client's ongoing interaction with the counselling service. | As above, with no reference to previous calls. |
| 7th and ongoing contacts | The counsellor engages therapeutically with the client as per the therapeutic plan aiming to achieve recovery in accordance with the agreed goals. As appropriate, progress is reviewed and adjustments to the therapeutic plan are made. | As above, with no reference to the previous calls. |
| Clinical Care Network | When working with the client to develop the therapeutic plan, the counsellor will assess the client's needs and interaction with other providers. Where appropriate, and with client consent, the Counsellor will seek to develop a clinical care network with the other providers so that all services are working with reference to the client's stated needs and recovery goals. | Referral to other services may be repeatedly made. |

## Budget

| | | | | |
|---|---|---|---|---|
| **Service Establishment – 20 weeks** | | | | |
| | Wages | | | |
| | | Project Manager | 45,914 | |
| | | Researcher and Assistants | 139,410 | |
| | | Training Manager and Trainers | 139,410 | |
| | | Administration | 66,527 | |
| | | On costs | 50,864 | |
| | Wages Subtotal | | 442,125 | |
| | Management | | 66,318 | |
| | Recruitment and Orientation | | 22,106 | |
| | Operations | | 154,743 | |
| | Travel – training and emergency services visits | | 40,000 | |
| **Service Establishment Total** | | | | **725,292** |
| | | | | |
| **Premises** | | | | |
| | The additional staff accommodation requirements will immediately exhaust the organisation's current premise capacity. A new premise will be required. Cost will depend on location, required fit out, IT connection, and relocation costs. This may be offset by corporate, in-kind and foundation support. This cost is an estimate only. Actuals will be negotiated and invoiced. | | | **1,000,000** |
| | | | | |
| **Annual Recurrent Costs** | | | | |
| | Wages | | | |
| | | Project Manager | 119,377 | |
| | | Counsellors + penalty rates<br>3 x day shift, 5 x evening shift, 2 x night shift x 7 days | 1,873,101 | |
| | | Supervision | 358,131 | |
| | | Researcher and Trainers | 238,754 | |
| | | Administration | 259,454 | |
| | | On costs | 270,349 | |
| | Wages Subtotal | | 3,219,163 | |
| | Management | | 386,300 | |
| | Operations | | 482,875 | |
| **Annual Recurrent Annual Costs Total** | | | | **4,088,338** |

**Budget Summary**

| | | |
|---|---|---|
| Year 1 | establishment, premises, 32 weeks service provision | $4,241,191 |
| Year 2 onwards | | $4,088,338 |