DAY 1 – Global Paramedic Leadership Alliance Employee Mental Health Summit – 21/22 March 2019

Resetting the scene

Overview – Suzanne Rastrick, Chief Allied Health Professions Officer

Reflection – it's ok not to be ok.

For discussion:

- How has the situation progressed, plateaued or regressed?
- How to main momentum and focus?
- What barriers do we now face?

Last year we discussed:

- Champions, how to measure success, commonalties, what are the next steps, future meeting?
- We agreed to use basecamp for filesharing
- Test sites to push out material
- Need to support research and peer support
- Commitment to future dialogue
- Holistic mental health

UK progress:

- Formal government legislation regarding independent prescribing
- Bachelor degree for registration
- Rotational pilots
- Clinical supervision is being explored
- Self-referral
- Paramedic Specialist in Primary and Urgent Care framework
- Job planning guidance for allied health professionals

Australasia – David Waters

There are 10 ambulance services which form the Council of Ambulance Authorities (CAA). There is a low population density which brings challenges. However, there is a representative for mental health from each service who meet regularly.

The 10 steps strategy

- All services signed up.

The 10 steps strategy was shared with the GPLA last year – and has been also adopted by members.

1. Promote a positive mental health culture in the workplace through leadership, communication, policy and procedure, environment and work/job design.
2. Reduce stigma around mental health conditions and psychological stress in the workplace.
3. Improve the mental health literacy of the workforce.
4. Develop the capability of staff to interact with and help someone experiencing a mental health crisis, from identification through to return to work.

5. Ensure that an integrated approach to mental health and wellbeing is woven through the workplace and that leadership at all levels model behaviours and practices that promote a mentally healthy workplace culture.
6. Share examples of best-practice and effective initiatives between services.
7. Collaborate to ensure staff, during each phase of their career have adequate self-awareness, knowledge and support in relation to managing their personal mental health and psychological stressors.
8. Implement systems that provide the service with early notification of potential psychological harm related risk.
9. Collect, monitor and respond to data that evaluates the mental health and wellbeing of the workforce and the possibility of psychological harm occurring
10. Seek internal/external specialist expertise when necessary to achieve improved mental health and wellbeing outcomes for the workforce.

What's changed? And a survey!

1. Promoting positive mental health – there is a standalone strategy from each service. This means that you can provide individual strategies if needs be.
2. Reducing stigma – individual services have put in place strategies for reducing stigma.
3. Improve: Queensland published a reference document on this with the aim to improve mental health literacy. Paramedics in Australia/NZ are all degree qualified now. The mental health component of the degree wasn't that strong in the past and now all degrees include this as a significant component. Mentorship and coaching are also covered at university level. This aids transition and peer support.
4. Develop capability of staff: the focus has been on identifying mental health issues in the workplace.
5. Ensure: All services have an employed psychologist with relevant knowledge and expertise. Also $30million dollars has been granted by the government for improving mental health.
6. Implement: standalone initiatives.
7. Seek expertise: Liaising with experts as well as relationships with Beyond Blue/Black Dog.
8. Collaboration: standalone initiatives.
9. Collect monitor and respond: continuous research and data collection.
10. Share and measure improvement – a report has been carried out.

Answering the call – Beyond Blue

This study had 21,000 respondents from within all emergency services; 1/3 of respondents were from the ambulance services.

Had previously put together a survey tool and implemented this – the next step was to analyse findings and think about addressing these.

The survey showed:

- 2/3 employees have high levels of resilience. However, 1/3 reported in high levels of distress.
- Emergency personnel were twice as likely to suffer from mental health difficulty than general public.
- Poor workplace culture was shown to be as damaging as occupational trauma.
- The longer an employee was in the job the more likely they were to experience mental health problems (or PSTD).

Agency recommendations

Agency recommended to address the unique agency findings.

Each emergency service had its own individual report.

- Employees had a lower mental health score than volunteers.
- Survey showed that 10.7% police employees had probable PTSD with the ambulance services 8.2% Therefore these statistics were not higher in ambulance services, although there was not much variation within EMS.
- 22% ambulance employees had a current diagnosis of a mental health condition.

Summary

- The majority of EMS have good levels of mental health and resilience. However, compared to the general population the levels of mental health distress are higher.
- Police showed highest levels of mental health distress.
- Suicidal thoughts are low but above average compared to the general population. The ambulance service does not have higher levels than other EMS employees.
- Impact of workplace.
- PTSD is more likely the longer you are employed within EMS.
- Other data showed:
    - More the 50% employees claimed to have poor sleep
    - 20% employees exposed to bullying
    - Verbal assaults were common
    - Stigma levels are still high
    - Former employees also need to be considered– this needs work as the data is still too new

What makes a resilient worker and organisation?

A resilient worker:

- Good physical health
- Good levels of sleep
- Makes use of support networks
- Strong social supports at work and at home

A resilient organisation:

- Team environment
- High levels of social support
- Commitment to wellbeing of staff
- Creates time for recovery
- Inclusive and fair
- Low levels of bullying
- Balanced flexible worklife

Canada – Nick Carleton and Renee MacPhee

A coast-to-coast team – CIPSRT. The mission: To improve life time health and wellbeing of public safety personnel

Government funding 2018/19:

- $20million –to support a new national research consortium
- $10million over 5 years – to create iCBT model

New piece of work is in progress putting together a national PTSD framework. PTSD is a government priority. The framework will be tabled in parliament by December 21 2019

What have we done?

- Research growth
- Work to mental readiness programme (R2MR)
- master trainers in every province
- online version of train the trainer programme (all via volunteers)
- Peer reviewed publications
- National policy consultations
- Charity networks

Research

CIHR approved 22 research projects in consortium funding with CIPSRT.

Exposure research showed that there's not a specific subset of incidents that result in PSTD. No specific associations leading to PSTD, but one is still more likely to experience PSTD if they have experienced traumatic events.

Prevalence study – showed that many respondents were not fans of psychiatrists/family assistance programmes/managerial support. They would prefer to talk to their spouse as first port of call. Should we be talking to the spouse?

A qualitative study showed the top requests from personnel were:

- Recognition from public and government for their work
- Improved resources

Next steps

- A Longitudinal Study of Operation Stress Injuries – 9-year project. Starts in April 2019. The aim is to change leadership training.
- Pilot of iCBT (using an Australian model).
- CIPSRT online – new website

USA – Pat Songer

The US is fragmented system and this correlates to the mental health issue in terms of access, costs, stigma.

NAEMT Survey

There has been an increase in suicides in the US. An NAEMT survey in 2016 showed no reduction in suicide rates.

Types of Mental Health services – 28% reported their EMS agency provided peer support programmes and only 5% provided resiliency training.

First Responder Survey – University of Phoenix

The University of Phoenix carried out a survey of 2000 employees (firefighters, police, EMT/paramedics and nurses):

84% of respondents experienced traumatic event on the job.

Current efforts

There has been a positive culture shift to PTSD to PTSI in order to reduce stigma and show this not as a 'disorder' but an injury.

Other efforts include:

- Integrated wellness programme
- PTG education
- Growing resiliency in EMS toolkit

In summary: there is still lots of work to be done.

UK – Will Hancock

NHS Long-term plan – 2019–29: 'renewed commitment that mental health services will grow faster than the overall NHS budget, creating a new ringfenced local investment fund worth at least £2.3 billion a year by 2023/24. This will enable further service expansion and faster access to community and crisis mental health services for both adults and particularly children and young people'.

Therefore there is more funding being invested into the mental health sector.

Our focus

- The creation of a suicide register/database (as per recommendation of 2017 suicide study). We hope to roll out this programme within individual services and work with NHS employers/unions and College of Paramedics in putting together toolkits.
- Review of occupational health, counselling and support services and sharing best practice.
- Development of ambulance service workforce support pages

Further research

AACE suicide study 2017 has encouraged further research.

Compassionate leadership

Refer to Michael West's presentation earlier in the week at the Ambulance Leadership Forum (ALF).

Compassionate leadership includes authentic listening and two-way engagement.

Sector/organisational intelligence

Various publications concerning bullying, harassment and culture in the ambulance workplace

Prof Duncan Lewis (University of Plymouth) coined the term 'level of incivility'. This links to inequality and discrimination in the workplace along with micro-aggressions and 'banter'.

This appears to be very common in UK ambulance stations where there is arguable a level of managerial detachment.

Engaging with staff

A 12-month project from the NHS seeking staff views to inform improvements for patients and staff (Project A)

Ideas by popularity were filtered by popularity and staff well-being topped the list of topics

The four collaborations were as follows:

- Mental health for patients
- Fallers

- Community collaboration
- Staff well-being

These were the key four areas as filtered by popularity.

Freedom to speak up guardians

Role originated after inquiry into Mid-Staffordshire NHS Foundation Trust to encourage whistleblowing. An independent guardian works with NHS trusts to ensure that staff feel able to 'speak up' regarding problems.

Staff survey results

Ambulance service have the poorest results (staff satisfaction) in the NHS but there has been improvement in recent years from sector as a whole.

Acknowledgement/recognition/focus and managerial style seems to make the most difference. More people are also filling out the survey than in previous years.

Working with Charities

Mind Bluelight Programme findings indicate that more tools of support are available. These tools are not necessarily via the organisation. Independent support is sometimes more accepted due to stigma.

In summary

- Moving in the right direction
- Greater understanding of the situation
- Committed at the local and national organisational level; cultural change is happening but not at great pace.

The Aspiration

Australasia - What does a well paramedic look like? Raelene Hartman

The Why of Wellbeing

The University of Western Australia carried out a large survey. This showed that the majority of staff had high levels of resilience. However the police and emergency services were still shown to have a higher risk of psychological distress: 22% of staff had some kind of psychological diagnosis.

Prior to funding NSWA: dedicated coordinators for peer support programmes. Health coaching and fitness. Ambulance management qualification, chaplaincy programme,

2016/17: $30 million investment with the aim to reduce physical and mental injury rates.

To focus upon:

- Well Paramedic (mental health and resilience, health workplaces strategies team, enhanced well-being, internal psychologists, enhancements to chaplains and peer support programmes)
- Safe Paramedic (Injury prevention and manual handling education, physically well, physiotherapy, strength and resiliency programmes)
- Protected Paramedic (measures against occupational violence, violence prevention officers, risk assessment)
- Capable Paramedic (leadership, specialist roles and programmes in management

Mental Health and Wellbeing Strategy

Four pillars:

1. Wellbeing and resilience

E.g. Wellbeing workshop – all staff attending over three years. There are also wellness checks post-training. More pro-active approach to mental health issues as opposed to being reactive.
Some concerns were raised about confidentiality with inhouse psychologists – these are being worked through. On the whole the approach been a success

2. Mental health literacy – Education / resources including signs and symptoms
3. Support culture
4. Health and safety – occupational violence etc

NSWA uses an integrated support model – these also includes staff/family and separated staff.

Wellbeing Workshop

- 3-day workshop using scenario based/situational awareness to educate workers in their wellbeing
- Implementation framework has been put together to evaluate the success of the workshop
- Hoping to investigate a range of different initiatives in future aimed at enhancing the wellbeing of paramedics alongside family support

USA: Growing EMS Resilience – Pat Songer

Resilience is the process of *adapting* well….

Training is particularly important increasing resilience – although often this training comes after a traumatic incident rather than in advance.

- Safe Call Now is a crisis call line for public safety employees which focuses on the family of origin
- NAEMT published a start-up guide to EMS Wellness
- Tania Glenn – private practitioners specialising in the different perspectives as unique to public safety (as opposed to general public).

Other measures

- Development of standards
  National EMS Management Association focused on peer support, stress education, culture, physical wellness and leadership
- Change: create plan, onboarding solutions, continuing education, healing navigation, support after the fact
- Reducing stigma
  Protocol, policies, procedure, organisational culture, clinicians who understand EMS, educations per support networks
- Wealth of resources in the US

Organisations that don't ….

- Poor organisational health
- poor productivity
- staff turnover

Discussion

What is the problem? To make a strategic plan and look at the importance of evidence in applying the practicalities

Feedback

1. Importance of funding and ensuring that staff have better resources; strategy

2. 3 days training vs 3 months off – long-term strategy is important!
3. Increasing momentum – it's important to start early and be more proactive (less reactive)
4. Divisions and barriers. Do we need better infrastructure and capacity in order to not overpromise and over-deliver?
5. Emphasis on clinical psychologists being on payroll, data being shared and importance of families.
6. Regular communication – could we act in a more structured fashion to share data.

Working Environment

Canada: Violence against Paramedics – Elizabeth Connelly

There has only been one study in Canada on violence against paramedics. There is some international research (e.g. from Australia), but only 34 studies anywhere.

However, research suggests that a high proportion of paramedics are experiencing violence as part of their role. This includes verbal, sexual, physical violence and bullying.

Also how do were determine both physical injury and psychological injury?

Research questions to ask

- What is the incidence and frequency of violence?
- What are the physical and mental health consequences?
- Is there any training in this?
- Can effective violence awareness and prevention training help address the problem?

The three-year plan

- Step 1. Administer the survey nationally and then pilot test
- Step 2. Undertake longitudinal survey and track employer metrics; develop and implement violence awareness and prevention programme
- Step 3. Violent awareness and prevention training programme evaluation; carry out qualitative research to analyse the success of the programme.

What is missing?

- Different perceptions of violence could be a challenge.
- Should we consider more about feeling safe.
- It's possible that certain individuals may attract violence?
- How do we identify the risk factors? E.g. alcohol, domestic violence?

UK: HCPC People like us: understanding complaints about paramedics – Liz Harris

HCPC commissioned a report looking at paramedic complaints in October 2017. This is available on their website. It aimed to look at the number and nature of complaints to the HCPC and to consider what actions might be taken to reduce the number of complaints.

Referral rates

The report showed that the average referral rate was disproportionate. Why is there a disproportional number of complaints and what can be done?

Average referral rate across all HCPC 16 professions was 6/1000

Paramedic referral rate was 11/1000

Methodology

- Literature review,
- Delphi exercise,
- Interviews,
- Focus groups,
- HCPC FtP case analysis.

Case analysis

Analysis showed that although many were referred, a high proportion were overruled.

- Did not find a disproportionate no of complaints leading to a judgement of impairment.
- Research showed that a disproportionate number of referrals did not need further investigation.

The average self-referral rate of paramedics is 46% compared to a of 6% average across all professions

84% of these self-referrals resulted in no further actions.

Four key themes

1. Public/societal expectation
   Struggling to meet societal expectations plus media pressure

2. Pressurised work environment
   Not enough staff, stress/sickness, mopping up, no time for training

3. Evolving nature of the profession
   Why should I change? Embryonic profession; Professional values; Emphasis on upskilling, professional values, embryonic profession, generational divide

4. Challenging work practices
   Practising defensively; frustration that builds; unsupported and 'heads down and get on with it' approach; covering up mistakes.

Summary

- A move away from technical/procedural complexity towards interpersonal/psycho-social complexity
- The concept of "right touch" regulation
- Negative aspects of culture which could be addressed through employer-led engagement processes

USA: Situational Awareness – Scene not safe – Sean Caffey

Theory of the case – providers are subject to violence

Societal factors influencing violence include:

- Alcohol
- Substance abuse
- Mental health
- Racism/ sectarianism
- Poverty

- Radical ideologies
- Access to weapons

Key questions

- Are we adequately preparing our workforce to understand and and assess risk factors for violence?
- Can our practitioners effectively de-escalate, evade and minimise violent encounters
- What are we doing do enhance awareness of the long-term effects of repetitive stress and build resiliency?
- How do we integrate these concerns in a coherent way?

Multiple approaches needed:

- Awareness of local conditions
- Increased behavioural health assessment
- Improved substance abuse assessment
- Training in de-escalations
- Awareness of cumulative stress

Existing programs and standards

- Community paramedic curriculum
- MHFA
- SAMHSA online courses
- Escaping Violent Encounters for Healthcare profs
- NAEMT EMS Safety and tactical care course
- NFPA 3000 Active shooter
- Evolving wellness and resiliency programme

Project goal

The aim is to assemble a street safety programme – this will be a mix of online and in-person training including case studies

Next steps:

- Develop partnerships
- Assemble curriculum
- Obtain local law enforcement and social service partners
- Conduct trial academy
- Report results

Discussion and points of reflection

- Is there more we should or could be doing?
- How does the UK position on paramedic complaints compare with other countries?
- Are staff sufficiently situation aware?

Feedback

1. Given that there is a correlation for time worked and violence. Should we be looking at lengths of shifts?
2. Is it organisations who should be doing more – or is there a wider societal context? Should we do more in the society? Society often perceives providers as public *servants*.
3. Investigating assault and learning from Australian research as to why the assault happened. The root cause analysis is important
4. Increased involvement of police is noted

5. Public outcry against the perpetrators in terms of media backlash – can we also work with the positives rather than the negatives?
6. Staff cameras could be considered.
   The system not nearly as robust in self-referrals in Canada – and also note the importance of Colleges in the UK (although colleges are not intended to regulate the profession). The general consensus is that paramedic complaints are different outside the UK. Australia was not regulated until recently and contends only with serious complaints and low-level reporting. It is important to share information in order for other countries to learn from the challenges in the UK.
   Technology could potentially also be utilised in simulation learning techniques and flagging individual patients as per case by case. Feminisation of workforce has increased in recent years. Therefore not only situational awareness needs to be addressed but additional support and de-escalations along with ensuring employees do not put themselves in a risky situation at all.

Hearing from our Staff

UK Project A – Ian Baines

The world is changing from top down

- Now more access to information
- Less reliant on experts/leaders
- Interconnectivity

Where we need to get to?

The aim is to have 4/5 ideas that can be implemented by ambulance trusts in the UK over the next 12 months

Myron's maxims

- People own what they help create

This involves connecting the system to itself and a 'bottom up' approach.

Launch event 28th June.

- Film-making; falls assessment service; Project A

Ideas platform

- Launched 12th of July
- Publicly available website asking ambulance staff what they think.

Frontline staff have been very engaged on social media. This give employees a voice and seems to be the preferred method of engagement

326 ideas came from Twitter! And the response to ideas was overwhelming

89 ideas which were actionable… lots of these related to staff well-being.

Innovation burst 25/26th September

This was a virtual innovation burst but all 10 ambulance services were represented

We're now working on a directory of good ideas available on the AACE website.

Improvement collaboratives which allows space for stories and for people to connect and share

Project A is 90% virtual!

Final thoughts

- The world is changing, connect people to make change happen
- Co-create not buy in
- Go where the energy is
- Heart and head.
- Sharing is good
- Focus on what people want

Australia - CAA: Global mental health survey – Mojca Bizjack-Mikic

Context of mental health working group

- Supportive board of CEOs
- Collaborations/Knowledge
- Strong work in the national/international space despite 10 different services.

Global mental health survey

David spoke about Beyond Blue survey as funded by the govt. Once the survey was finalised the CAA took information from the survey/learnings/tools.

We now want to extend this internationally – including fire, police, EMS services

This would be run every 2 years with a global launch in 2020

The rationale behind the global survey includes:

- Obtain actual data
- Measure our work investments
- Promote our great work
- Negative publicity

Launch of 10/10 day. Website has self-assessment tool (from Canada) which is being developed into an app. E.g.: How am I doing today? Checklist. Social media influencers

It assesses wellbeing but also gives you practical advice if you are in the 'red'.

2019 plans

- App
- Social media
- Video messages from leaders and influencers.

Reflection: What surprised you?

Feedback

1. Consider if there an opportunity to approach the alliance with the data sets of the different countries to put something forward and pull this together.
2. A list from all countries of data (on mental health and PTSD) should be assembled into one place. A repository is available but not necessarily the resources for the analysis. #StrongerTogether
3. How much work HAS been done?
4. Focus more on family and the benefits of personal resilience / recruitment
5. There is a commonality of themes around the globe. Although some places have more funding then others some solutions are cheap. We can look outside the service too… signposting is important
6. NSW psychologists should how the use of money can be so effective. Spouse/family is an obvious point but hasn't previously been considered. Is it intrusive to involve the families in these matters

DAY 2- GPLA

Questions to ask ourselves today:

- How to test for resilience in new paramedics?
- How to not be intrusive?
- What is a psychologist's role within a multi-professional team?

Leadership

USA: Leadership through Darkness – Pat Songer

Traditional leadership models have had a 'move on to the next call' focus. This also brings with it various barriers:

- Leaders acceptance of tradition
- Fear of judgement
- Difficulty with resources
- Fear that seeking treatment will damage their career
- Leader Culture
- The helpers may need help the most
- Bravado

We need to think about leadership in a different way. There are also limited resources for EMS. Should we be preparing employees at an earlier stage?

Spring 2014 ASM Survey

Survey completed by the Spring 2014 ASM group with 4021 respondents showed:

- 85% experienced critical stress
- 66% did not seek help

Suicide was also shown to be above the national average in the EMS sector. However, when there is leader involvement the probability of suicide decreases.

Only 48% felt support from management.

Were EAPs helpful?

Many did not feel that EAPs were helpful. In some cases, the provider didn't get it, or people were not contacted by EAP.

Therefore leaders must change

- Entry into EMS
- Resilience and resistance training
- Continued education
- Navigation

EAP system should also change to be more suitable for public safety.

Leaders can make the change and paying attention is important.

Change is happening

- Pre-employment screening
- Entry education
- Stigma and taboo of mental health awareness
- Leadership support increasing

- Increasing resources available for mental health injuries
- Navigation of our providers increasing
- Peer support teams

Canada: Impact of technological evolution on leadership – Doug Socha

System development is really important in order to avoid errors.

Trialling the use of technology for system development:

- Dispatch information and patient information can be sent in advance so the paramedic can prepare for the call on arrival.
- Auto vehicle locator can prepare for any traffic on the way
- Situational awareness technology to support patient care and also support the paramedic at the same time.

Planning test at the end of the month to see how effective this process is. It is known as the Audrey experiment.

Smart glasses and drones are also being considered.

Real time data and dashboards show no of units available, how many are on call, how many at the hospitals, time intervals etc.

Putting these initiatives together may present a new era to support paramedics in decision-making from a systems point of view.

As leaders are we prepared for the impact of new technologies? There can be a generational difference in adapted to new technologies and it is important not to get left behind.

Could the Audrey experiment integrate Alexa? This may be a possibility in future.

Australia: How a good leader can prevent potential psychological trauma – Todd Wehr

A leadership role is often based around KPIs rather than being engaged with people

Issues in organisations not linked to trauma as much as they are dealing with management problems.

Mental health training package

The mental health training package been taking place for the last ten years – it studied issues with managers but also the issues from managers themselves. It has found managers really want to support their staff.

Issues arising during workshop:

- Confidentiality
- Raised awareness of MH resources but not convinced it was for them
- Feeling neglected
- Felt as though the had to be 'headkickers'
- Caught between system and empathy
- Impact of generational gap
- Heavy workload
- Difference between urban rural respondents
- Impact of non-traumatic stressors
- Issues of confidentiality and mistrust

Managerial Empowerment

Managers actually felt disempowered as they didn't feel as though they could help with mental health issues. Therefore there is a need for managers to be empowered and know why mental health is important.

QAS leadership investment

- Trauma in the Workplace – training for all Managers and Supervision
- Critical Incident Management Training
- Classified Officers Development Programme (CODP) 1, 2, 3
- Critical Care development programme (CCDP)
- Managers coaching and mentoring

The Neuropsychology of Trauma - The Limbic System

The amygdala part of the brain is important - it 'fires off' in when under threat. This stimulates the pituitary gland, and the prefrontal cortex (the rational part of the brain) is blocked. The hippocampus records the 'history' of the event and body goes into 'flight', 'fight' or 'freeze' mode (or a combination of all three)

The can cause a vicious loop and mixed narrative. Therefore the stress response can continue over days or weeks – it doesn't stop instantaneously.

- Exercise can help as it burns off cortisol
- Talking about it can also help…. This is why management is so important in negating these effects.

Trauma management and building resilience

Many managers don't realise they have a legal responsibly to look after the mental health of their staff.

Key points for managers:

1. Immediately provide a sense of safety to calm down the amygdala
2. Provide staff with a sense of control – find out what they need – listen
3. Support needs to be consistent and authentic
4. Allow self-titrated talking
5. Exercise
6. Good sleep
7. Breathe!

Critical Incident Response – A stepped approach

It's very important to be able to educate individuals to look after themselves – managerial support and peer support is secondary

Post-traumatic growth also refers to positive changes an individual may possibly experience as result of a traumatic event.

Discussion

What more can we learn from each other in the quest for leaders to see employee mental health as a top priority?

In what ways can technology facilitate providers in their challenge to support staff?

Are our leaders sufficiently equipped to lead and what more do they need to do in the best possible way to look out for staff and patients?

Feedback

1. Resourcing levels are a challenge. We are not yet sufficiently equipped but roll outs of mental health training is helping and so the situation is getting better. This is currently at trust level. Seeking to address financial balance short-term may take away from a long-term plan. Also giving the managers space to address these issues is a challenge. How can we use investment to the best effect?
2. Learning from others to build the business case – we should be looking long-term instead of short-term. KPIs are a disincentive. Technology can also be used to assess and share information on mental health
3. A proactive approach needs to be emphasised... Leaders are not sufficient and therefore we need 'train the trainer' facilities.
4. Clinical supervision isn't the same as being competent.
5. Feeling that ownership should be back on the individual. And actually it's also ok to be ok. CEOs also have KPIs which filter down into organisational culture.
6. Top down approach and a more empowered middle tier. Lessons from research should be taken on board but also there should be contributors from frontline staff to ensure that the approach is meaningful. Could we potentially use a virtual method of clinical supervision (e.g. Skype)

Lessening the Pressure

Canada: Harassment in the Workplace - Mark Mason

Generally in Canada:

- Everyone has a right to be free from harassment/bullying and discrimination in the workplace
- Employer has primary responsibility to ensure employees are not subjected to harassment and bullying

Definitions of harassment can vary – now the **Ontario Human Rights Code** includes sexual harassment

Also what is a workplace?

- Away from physical workplace?
- Outside working hours?
- Through emails and social media?
- Acts done in the course of the employment?

Definitions of harassment

Examples of harassment:

Words which are humiliating, demeaning or embarrassing. E.g. jokes, innuendo, verbal abuse, gossip humour, singling out or isolating, withholding benefits, setting impossible expectations, constant negativity, making unwarranted changes

Other considerations:

- Intent is irrelevant
- Not just male vs female or supervisor vs employer
- Employer vs employer harassment and bullying becomes increasing prevalent in and outside the workplace
- Union role?

Harassment is not….

- Evaluating and monitoring performance
- Setting performance standards
- Corrective/ disciplinary action
- Conducting Investigations
- Constructive criticism
- Performance appraisals
- Work-related stress
- Organisational change for business

Consequences may include:

- Human rights claims.
- Civil actions: e.g. constructive dismissal, tort claims

What to do with complaints

- Prompt response
- Awareness that conduct is prohibited
- Management must communicate its actions to complainant
- Must be dealt with seriously
- Must be a complaint mechanism in place
- Employer must promote a healthy workplace environment

Examples include:

- Payette v Alaram Guard Security Service – sexual harassment claim - $23,000
- Sulz v Canada - supervisor had angry outbursts and victimised employee - $950,000
- Toronto Transit Commission and ATU - supervisor targets employee – selective performance management - $25000

Bill 127, Stronger, Healthier Ontario Act

The Workplace Safety and Insurance Act has now been adapted to incorporate chronic mental health as well as traumatic mental health. This hasn't increased the number of cases.

UK: Engagement and co-creation within a roster review - Chris Nelson

We looked at previous rota review attempts in SWAST.

What went well? Although there had been an element of engagement… maybe it was not the right kind of engagement.

What do our workforce actually want?

Challenges include:

- Long hours working hours
- Performance and cost efficiencies
- Increasing demand
- Changing shape of demand – Ambulance Response Programme
- Modernisation and standardisation of ways of working within the Trust
- Change is difficult – you have to plan to get it right!

Project resourcing and governance

- Aimed to have clarity concerning demand and core principles.
- Included a steering committee

- Resourcing in terms of subject matter experts, unions and project support team

Core principles

- Hours needed to be contractually compliant and legally compliant. Flexible working is key – allows employees to take ownership of the work
- 'Rules' for what each rota should achieve
- Working party approach and consultation with staff/unions – this promotes engagement and ensures everyone has a voice.

Interactive software

Interactive software was used to build patterns using the core principles:

- Automated find shifts and pattern design algorithms including
- Investigate multiple options quickly and easily
- Shift lengths
- Splits of shifts by employee group preference
- Rotations
- Weekend distribution
- Rest breaks
- Relief

The software looked at moving shifts with regards to preferences.

Benefits realisation

Staff felt empowered as they were part of this project (bottom0-up approach). They decided their own rotas.

There was a reduction in late shifts and meal break compliance improved, but primarily staff feel empowered and engaged.

Discussion

- How prevalent is workplace harassment? Is there more we could/should do collectively?
- How realistic are negotiated rota patterns for real staff and with what envisaged effect on employee mental health?
- In what ways have organisations effectively lessened the pressure?

Feedback

1. More data is required to know how often harassment occurs. However, there are legal obligations to consider.
2. We cannot always quantify harassment as it is often subversive and often tolerated. Mediation can be effective as well as setting boundaries between people to make things clearer. We can be more prepared.
3. There are several grey areas of harassment such as 'banter'. We should equip managers to deal with this effectively.
4. Do we put together a set of rules as to what is and isn't acceptable? White ribbon accreditation in New Zealand is a standpoint against domestic violence. It promotes the values and behaviours you expect of people/employees and the accreditation is retested on a regular basis.

Practical Application

UK: Mitigating Late Finishes- Craig Harman, London Ambulance Service

- End of shift arrangements often leads to burn out especially in a London environment.
- Employees are 40 minutes late off from work on average.

We took a collaborative approach to tackle the problems:

- Taking a break needed to be made a priority.
- Roster full patient facing time.
- Discovered that staff wanted to engage more via social media.
- Patient is still the first priority. How can we ensure the right balance between patient and employee care? E.g. those paramedics who have been on shift for 12 hours are probably not the best to deal with category 1 patient.

The arrangement

- Take a break
- If you have a break get a 30-minute protected time period at your end of shift. This is to ensure that employees have time to end the shift properly. E.g. medicine management
- Maximise patient-facing time.

Results

Handover to green – went down; rest breaks went up

Overall very positive feedback from staff – 89% felt that the pilot was a positive initiative for ambulance staff.

NZ: 2011 Christchurch Earthquake: psychosocial support – Daniel Ohs

Psychosocial behaviour

Immediate aftermath:

- Enhanced arousal
- Rational behaviour
- Maintenance of social structure

Medium/long term:

- On-going arousal
- Future worry
- Avoidance through recovery
- Automatic pilot
- Acceptance
- Limbo
- Convergence

There are three main components of psychosocial support:

- Individual measure
- Social ecology
- Culture and values

The individual

- Food, water and shelter
- Non-specialised support
- Specialist psychosocial support
- Support adaption to a new reality

Social ecology

- Empowerment and social support
- Manage and allow volunteerism
- Share information
- Community support

Culture and values

- Acknowledge community diversity
- Engage ethnic/cultural groups
- Encourage spiritual and religious practices
- Read your audience

Effective Psychosocial Support

Three fundamental points:

1. Support must address the psycho and social aspects of recovery
2. Measures must encourage acceptance of the changed reality
3. Measures must reflect research-based solutions

Next Steps

Points for consideration:

- What was the greatest learning point?
- Suggest three action points
- Do you feel that your focus and attention have been on the right areas in terms of mental health?

Feedback

USA:

We still have a lot to learn from each other. The USA role in future could possibly be to listen and disseminate information.

Australasia:

Family support is important as is the need for us to share information. We are also keen to learn from UK registration and avoiding possible challenges associated with registration.

We all agree that there is still more to do.

Canada:

There is lots going on but these initiatives are not always being translated to the frontline. We need to communicate globally.

Could we get people to send data to Canada? Can we also come up with a course for leadership? What is it in each country which allows us to act upon these things (for instance) funding? If we look what is working internationally then we can look at enabling these approaches elsewhere.

UK:

We should take a broader approach and avoid silo working. How can we bring it all together? This seems quite difficult to do.

There is a need to focus on how we support managers as well as frontline staff. We have noticed the role of family and the potential to move outside the immediate service.

We can communicate via basecamp if future – or emails to the GPLA email address

Ireland:

Educating managers is important in order to move away from the command and control model.

We would like to explore the role of family; resilience tests and the legacy idea.

Overall

We can use Basecamp for sharing information.

Having a strong evidence-base is really important. A collective agreement across all four countries would be really useful so we can share the empirical data.

Should we have touch points during the year via Skype in order to maintain momentum?