Phoenix AUSTRALIA
CENTRE FOR POSTTRAUMATIC MENTAL HEALTH

TrackSAFE Foundation

JUNE 2023

RAIL INDUSTRY TRAUMA MANAGEMENT FRAMEWORK

Acknowledgement of Country

Phoenix Australia and the TrackSAFE Foundation acknowledge Aboriginal, Torres Strait Islander, Māori and Moriori peoples as the Traditional Custodians of Country throughout Australia and Aotearoa/New Zealand.

We acknowledge the continuing connection of First Nations peoples to land, water and communities—places of age-old ceremonies, of celebration and renewal—and their unique contribution in the life of these lands.

We are committed to fostering an environment in which the relationship between First Nations peoples and their fellow citizens is characterised by a deep mutual respect, leading to positive change in culture and capacity across the globe.

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About

Phoenix Australia

Phoenix Australia – Centre for Posttraumatic Mental Health (Phoenix Australia) is a not-for-profit national Centre of Excellence in posttraumatic mental health, affiliated with the University of Melbourne.

Phoenix Australia's mission is to build the capability of individuals, organisations, and the community to understand, prevent and recover from the mental health effects of trauma.

Phoenix Australia translates research into effective policy and practice improvement work related to mental health and wellbeing, provides workforce development, training, supervision, and consultation services designed to minimise the potential adverse impact of exposure to trauma for individuals and organisations.

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TrackSAFE Foundation

The TrackSAFE Foundation was established in 2012 and is Australia's only harm prevention charity focused on reducing deaths, injuries and near hits on the rail network.

The TrackSAFE Foundation's mission is to prevent suicides and reduce accidents and injuries across the rail network, as well as improve the wellbeing of rail employees.

TrackSAFE Foundation

Acknowledgments

In 2012, the TrackSAFE Foundation hosted a best-practice forum with rail operators from across Australia and New Zealand to workshop best-practice in trauma management for the rail industry.

This led to the development of a draft skeleton of a *Trauma Management Framework*. Consequently, the TrackSAFE Foundation engaged Phoenix Australia to finalise the Framework to ensure it aligned with best practice for managing potentially traumatic events (PTEs) in the workplace.

Then, in 2023, the TrackSAFE Foundation sought feedback from rail industry representatives about the Framework and subsequently engaged Phoenix Australia to revise and update the *Trauma Management Framework* to align with current best-practice.

Phoenix Australia and the TrackSAFE Foundation would also like to acknowledge the contributions of representatives across the rail industry who provided valuable insights and consultation feedback for the initial Framework and revised 2023 version.

Suggested citation

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Executive summary

There is a predictable risk of exposure to potentially traumatic events (PTEs) in some segments of the rail industry. While most people are resilient and will recover without professional help, a minority are at risk of developing posttraumatic mental health problems.

The *Trauma Management Framework* provides a best-practice approach to managing trauma in the rail industry and thereby minimising the risk of adverse mental health outcomes.

Best-practice principles

Twelve best-practice principles for managing trauma before, during and after an incident underpin the Framework.

Optimal workplace culture

Workers in organisations with high morale are more resilient when faced with potentially traumatic incidents. Social support after an incident is the best predictor of recovery.

Whole of career approach

Employees' support needs can vary depending on where they are in their career lifecycle, so rail organisations should provide training and interventions tailored to an employee's level of professional experience and career stage. Recruitment is a particularly important process with unique considerations.

Incident record keeping

A reliable and comprehensive system to capture information about critical incidents, trauma management responses and outcomes for individuals has numerous benefits for managers, organisations and the broader rail industry.

Review, evaluation and continuous improvement

Implementation of the *Trauma Management Framework* should be evaluated and periodically reviewed to ensure ongoing best-practice.

Pre-incident

The organisation and individual employees should be prepared prior to an incident occurring.

Organisational preparedness involves the development and implementation of best-practice policies and procedures for managing trauma, as well as dissemination of staff education and training. Specific pre-incident preparation is required for high-risk roles, and involves education about potential immediate reactions to trauma exposure and strategies to manage those reactions.

Incident

Incident-related procedures should aim to minimise exposure to psychological hazards at an incident scene, support affected workers in fulfilling operational and legislative requirements and provide appropriate emotional support.

Post-incident

A three-level stepped-care approach is recommended for post-incident support.

Level 1, Psychological First Aid (PFA), refers to the immediate support and monitoring for all that can be provided by managers, first responders and/or peer supporters. Level 2 refers to brief, low intensity interventions for those who do not appear to "bounce back" provided by primary care, employee assistance programs (EAPs) and other counsellors or others in the staff group with appropriate training. Level 3 is evidence-based treatment, for the small minority who go on to develop posttraumatic mental health problems, delivered by mental health professionals. An expectation of recovery and return to work is fundamental to this Framework.

1. Introduction

1.1 Purpose

The purpose of the TrackSAFE Rail Industry *Trauma Management Framework* (Framework) is to provide information and guidance to the rail industry on the best-practice approach to trauma management for all rail employees. The Framework is intended to assist the industry to provide uniform, best-practice approaches that can help employers and individual workers prepare for and minimise the risks of adverse psychosocial outcomes following potentially traumatic events (PTEs).

It is acknowledged that each organisation will have unique strengths and weaknesses regarding their current alignment with best-practice, so this Framework is intended to help guide each organisation's journey toward best-practice trauma management.

1.2 Rationale

This Framework, that organisations can implement appropriate to their specific needs and context, aims to ensure the following:

- a clear and shared understanding of what constitutes a PTE across the rail industry and within each organisation, and therefore, when aspects of organisational procedures are activated;
- a consistent and proactive approach for minimising the impacts of PTEs, and providing support to workers that is timely, effective and in line with evidence and best-practice;
- a commitment to workplace and industry culture of evidence-based trauma management.

1.3 Audience

While this Framework is available to any person working in the Australian or New Zealand rail industry, the primary audiences for this Framework are senior leaders, managers, specialists, and advisors of wellbeing initiatives within rail organisations.

Depending on the organisation, these wellbeing leaders or specialists may sit within trauma management, people, culture, safety, health and/or wellbeing areas of the organisation.

1.4 Framework implementation context

This overarching Framework is intended to provide guidance to the rail industry about best-practice trauma management alongside relevant legislative requirements.

Within each organisation, there will likely be related policies, practices, supports and service systems that create each organisation's specific context for this Framework. Figure 1 on the following page provides an overview of the different elements that guide each organisation's journey towards supporting best-practice trauma management.

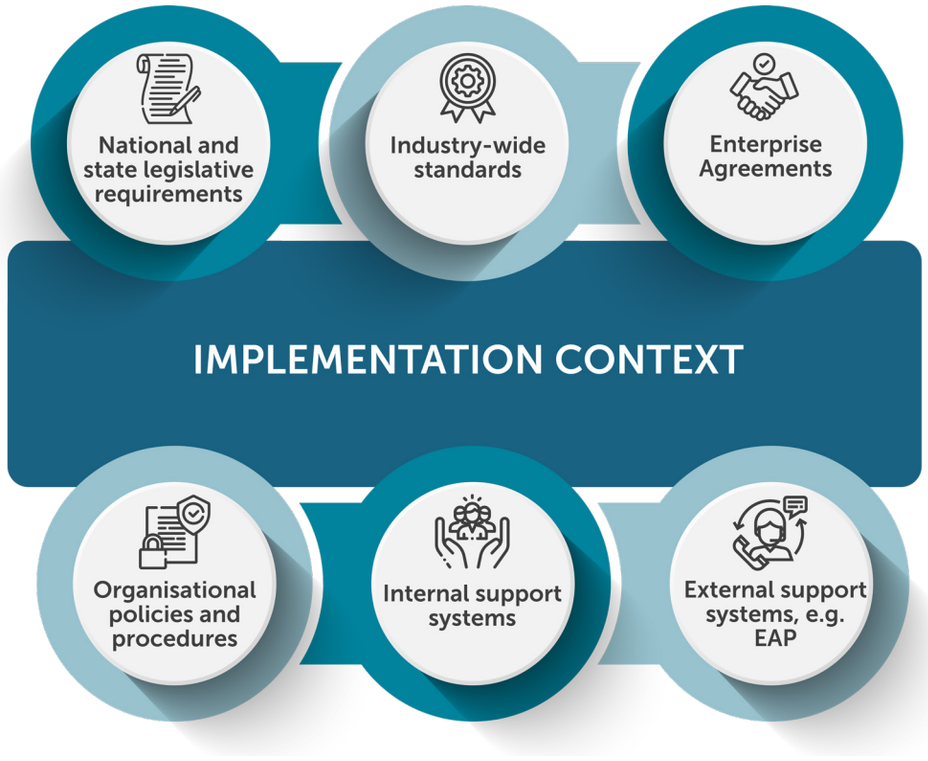

Figure 1. TrackSAFE Rail Industry model of documentation and practices that support best-practice trauma management.

This overarching industry Framework is intended to assist the rail industry and individual rail organisations embed best practice trauma management. For example:

- at an industry level, the Framework can be used to guide development of an implementation toolkit implementation toolkit which may include checklists, training materials and templates that could be tailored by individual organisations to their own needs;
- at an organisational level, the Framework can help organisations with benchmarking to understand the extent they are aligned with best-practice, and as needed, the Framework can guide development or revision of organisation specific policies, standards, procedures, and practices related to trauma management.


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2. Trauma and its impacts

2.1 Prevalence of trauma

Fifty to seventy five percent of people report at least one PTE in their lives, with most reporting two or more events. We also know the likelihood of being exposed to a PTE is increased for those working in high-risk industries, such as the rail industry[1].

Across the Australian and New Zealand rail industry any employee can be directly or indirectly exposed to a PTE in the course of their work.

Examples of PTEs include witnessing or being involved in an incident that involves death of serious injury, near misses, assaults and other aggressive behaviours, workplace injuries, medical emergencies, as well as disasters triggered by natural or man-made hazards.

PTEs can also include indirect exposure to details of a traumatic event in the course of their professional duties, e.g., hearing, reading, or seeing reports of trauma such as receiving a call with details of a traumatic event as part of a role in the control room.

Rail employees, like any other employee, may also be exposed to PTEs in their personal lives that can have an impact on them in the workplace.

All employees – train, tram, freight or light rail crew, station staff, managers, supervisors, investigators, track workers, rolling stock maintainers and other rail employees – have some risk of exposure to PTE.

There are however particular roles within the rail industry that are considered to be at higher risk of exposure to trauma, such as rail drivers, who Safe Work Australia identify as first responders and one of the most at-risk occupations for work-related mental disorders[2].

2.2 Impacts of trauma

Type, severity, and duration of reactions to a PTE can vary greatly, depending on the individual, and the circumstances in which they experienced the PTE.

Factors that impact the intensity of negative reactions include the frequency and duration of exposure to PTEs, the nature and intensity of the event, the perceived control over the exposure, and individual factors such as prior trauma exposure, personality style, and pre-existing psychological conditions. Common reactions to a PTE in the initial days and weeks following exposure can include, but not are not limited to:

- emotions and hyper/hypo arousal: feeling tense, easily startled, anxious, angry, or irritable, sad, fearful, helpless or hopeless, guilt and shame, shock, numb or detached, a sense of vulnerability or feeling out of control;

[1]Phoenix Australia. (2020). Australian Guidelines for the Prevention and Treatment of Acute Stress Disorder, Posttraumatic Stress Disorder and Complex PTSD. www.phoenixaustralia.org/australian-guidelines-for-ptsd/
[2]Safe Work Australia. (2022). Managing Health and Safety, Mental Health: Psychosocial Hazards

- physical changes: difficulty sleeping, digestive problems, experiencing aches and pains, headaches or teeth grinding;
- changes in thinking: reduced concentration and memory, difficulty making decisions or poor problem solving, intrusive thoughts, images or nightmares, a change in worldview that could include perceiving the world as unsafe or others as untrustworthy;
- behavioural changes: avoiding trauma-related reminders, increased substance use or risk-taking behaviour, reduction in work performance, workplace conflict or discipline matters.

While most people are resilient and will recover from exposure to a PTE without professional help and with the support of family and friends in the weeks after the event, a minority of people can go on to develop a mental health disorder.

The most common mental health disorders that develop after a PTE are depression, anxiety disorders, posttraumatic stress disorder (PTSD; sometimes referred to as posttraumatic stress injury), and substance abuse, however, people may experience a range of other chronic psychosocial impacts[1,3]. Of note, some people may show delayed impacts when a later event or situation triggers them, some may show signs in the context of cumulative exposure to trauma, and some may show a relapse in symptoms in relation to an earlier PTE.

It is challenging to attribute a response to a PTE solely to the circumstances of the exposure. In many instances, the individual may be further impacted by difficulties in their personal life or organisational factors that are present in the rail industry such as shift work, working alone, low job control and exposure to multiple PTEs (see next section on managing other psychosocial risks).

Posttraumatic mental health conditions are associated with significant emotional, social and economic impacts for the individual, their family and friends, and the workplace.

Minimising these impacts will not only improve employee wellbeing but bring benefits to the rail organisation in ensuring legislative and regulatory compliance, improved lost time injury frequency rate (LTIFR) and total recordable injury frequency rate (TRIFR), and savings in workers compensation claims.

2.3 Managing other psychosocial risks

Safe Work Australia and WorkSafe New Zealand state that everyone has a role in managing psychosocial risks, including PTEs, in their workplace.

Work health and safety related legislation sets out requirements about preventing employees being harmed at work, and as part of this, organisations need to have measures in place to provide a psychologically safe and healthy work environment and have established risk mitigation approaches.

Further, each rail organisation needs to be cognisant of other relevant legislation and how this should be read in the context of this Framework. Safe Work Australia defines a psychosocial hazard as anything that could cause psychological harm, e.g., harm someone's mental health.

Common psychosocial hazards at work include: job demands, low job control, poor support, lack of role clarity, poor organisational change management, inadequate reward and recognition, poor organisational justice, PTEs or post traumatic material, remote or isolated work, poor physical environment, violence and aggression, bullying, harassment, workplace conflict or poor workplace relationships and interactions.

Psychosocial hazards can create stress which can cause psychological harm. While some hazards may not create risks on their own, they may if combined with other hazards. Both an employer and any person undertaking work has a responsibility to contribute to eliminating psychosocial risks or to minimise them so far as it reasonably practicable.

This *Trauma Management Framework* focuses on providing guidance about best-practice principles to minimise the risks associated with direct or indirect exposure to trauma.

[3]Bonanno, G. A. (2004). Loss, trauma, and human resilience: have we underestimated the human capacity to thrive after extremely aversive events? American psychologist, 59(1), 20.


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3. *Trauma Management Framework* overview

The key components of the *Trauma Management Framework* are illustrated in Figure 2 and explained in further detail in later sections of this Framework.

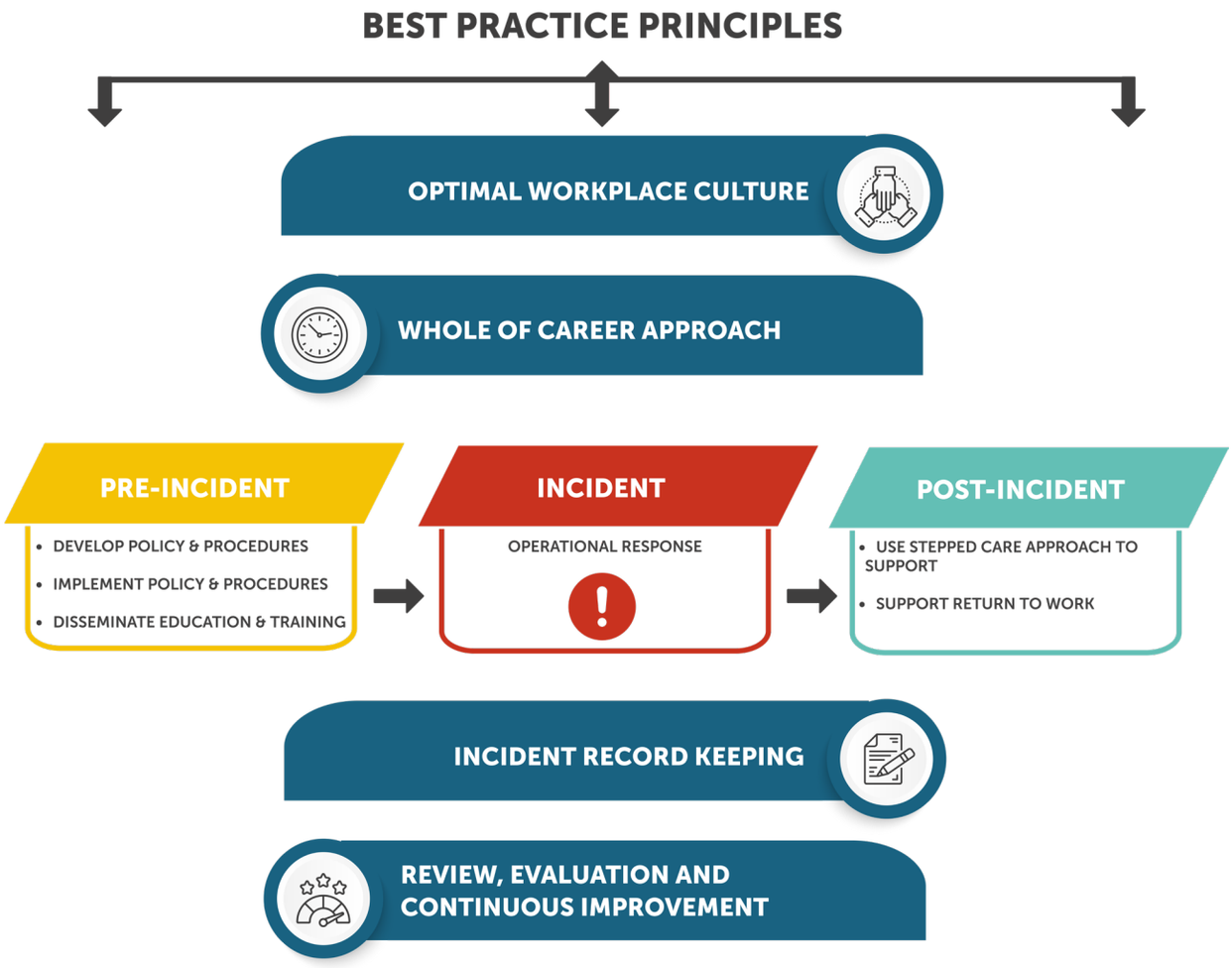

Figure 2. TrackSAFE Foundation Trauma Management Framework

4. Best-practice principles that underpin the Framework

The *Trauma Management Framework* is underpinned by twelve best-practice principles derived from research and practice, and aligned with the stepped-care approach[4] to mental health support.

These principles are integral to a holistic program that has the best opportunity to be adopted, accepted and successful.

These principles should underpin communication about trauma management to employees at all levels of a rail organisation, to encourage engagement in relevant education and training, compliance with appropriate procedures, and a commitment to best-practice trauma management in the workplace, from the outset of employment.

Within Figure 2, there are three key phases in PTE management – what can be done to prepare an individual for potential trauma exposure, what can be done to support them during a PTE, and what should be done post-incident. Best-practice for each of these key phases are presented in further detail in Table 1 on the next page.

[4]A stepped-care approach to mental health support refers to a process where different levels of mental health interventions are matched to individual needs with 1) universal interventions made available to all employees to prevent or minimise the impacts of exposure to PTEs; 2) early low intensity support for employees with emerging mental health issues; and 3) specialist mental health and return to work support for those who develop more entrenched mental health issues.

The following sections provide a breakdown of the other key components of the Framework that were illustrated in Figure 2.

Pre-incident preparation	Incident response
1. There is a predictable risk of exposure to PTE's in the rail industry and, as such, rail organisations have a responsibility to have policies and procedures in place designed to minimise the impact of trauma on their employees. 2. Effective trauma management requires a commitment across all levels of the organisation, with roles and responsibilities of management, supervisors, peers and staff clearly defined. 3. Managing trauma should be considered as a stand-alone risk, but not at the exclusion of the general mental health and wellbeing of employees. Policies and procedures that raise awareness of mental health in the workplace, and promote the mental wellbeing of staff are an important basis for the introduction of specific policies to manage trauma.	1. Effort should be made to minimise the number of people exposed to a PTE and the length of exposure to psychological hazards. 2. Distress, shock or numbness at the time of trauma is to be expected and is not a sign of mental health disorder. 3. Adaptive coping can be promoted by helping those affected to maintain focus on their work role as far as is practicable and safe (both physically and psychologically) to do so.

Table 1: Guiding principles for pre-, incident and post-incident trauma management.

Post-incident response

1. Perceived social support following trauma is the best predictor of recovery. In the case of workplace trauma, the support of peers, supervisors and managers is critical.

2. Most people recover from trauma without professional help. All interactions with employees exposed to trauma should promote positive expectations of resilience and recovery.

3. Immediate distress can be assisted with simple validation of reactions and emotional support.

4. A mechanism that allows for timely identification of individuals experiencing ongoing difficulties is required. There should be routine and "low key" procedures to monitor the wellbeing of everyone exposed to trauma (consistent with the principles of Psychological First Aid).

5. Early access to evidence-based care should be provided for those who do not appear to be "bouncing back", with a focus on effective treatment facilitated by an appropriately trained person.

6. Return to work after trauma or injury and providing opportunities to remain connected to the workforce (as appropriate for the individual) should be promoted as beneficial for recovery as well as the long-term health and wellbeing of employees.


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5. Establishing an optimal workplace

Purpose: Efforts to minimise the impact of workplace trauma need to begin before a traumatic event, with consideration of the workplace culture of the organisation.

Research shows that factors within the workplace can promote or impede resilience and recovery in staff exposed to trauma at work. There are two key mechanisms that seem to underpin an optimal workplace:

- morale – employees in workplaces with strong morale are more likely to be resilient[5];
- social support – the perceived support that a person receives following a traumatic event is the best predictor of recovery[6,7].

When there is a predictable risk of trauma exposure at work, a supportive workplace with team cohesion and high staff morale, provides the optimal conditions for maximising staff resilience and recovery.

In seeking to create an optimal workplace culture, efforts should focus on factors found to influence staff morale. These include:

- clarity around defined roles and responsibilities, and clear lines of accountability;
- fair, transparent, inclusive and equitable employment, performance management and career development protocols;
- clear and transparent work health and safety policies and procedures including well established risk assessment and risk management practices, bullying and harassment policies and procedures, Employee Assistance Program (EAP) service access and availability;
- frequent, easily accessible and supportive supervision;
- flexible and inclusive work practices that allow individuals to establish a healthy work/life balance (e.g., space to prioritise and manage family responsibilities, capacity to implement a sustainable physical exercise regime, access to healthy food options etc.);
- regular team meetings and/or staff forums where staff can both access information and have a chance to provide input into or feedback on decision making, including strategic planning;
- opportunities for and ready access to operational debriefing (not psychological debriefing) following stressful work-related events;
- establishment of routines, practices and traditions that build a socially supportive and inclusive workplace free of bullying and harassment, and aligned with diversity and inclusion principles, particularly regarding listening, linking and respecting;
- regular and repeated workplace training to ensure development and maintenance of required core skill competencies.

Efforts should also focus on mechanisms to ensure that staff involved in a PTE can overcome barriers to help-seeking and access early appropriate support. For this to occur, there needs to be a workplace culture that demonstrates the following across leadership and employees that:

- acknowledges a range of incidents that occur in the rail industry as potentially traumatic;
- recognises the potential mental health and wellbeing impacts of exposure to traumatic events and validates the reactions of individual affected workers;
- provides appropriate support at all levels of the organisation;
- communicates commitment to mental health, and expresses care about the individual and their family;
- provides a range of flexible and inclusive support options, as well as timely and effective pathways to care.

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[5]Hart, P. M., & Cotton, P. (2003). Conventional wisdom is often misleading: Police stress within an organisational health Framework. In Occupational stress in the service professions (pp. 117-156). CRC Press.
[6]Brewin, C. R., Andrews, B., & Valentine, J. D. (2000). Meta-analysis of risk factors for posttraumatic stress disorder in trauma-exposed adults. Journal of consulting and clinical psychology, 68(5), 748.
[7]Ozer, E. J., Best, S. R., Lipsey, T. L., & Weiss, D. S. (2003). Predictors of posttraumatic stress disorder and symptoms in adults: a meta-analysis. Psychological bulletin, 129(1), 52.

Importantly, establishing an optimal workplace culture is not something that can be dictated by management; rather it builds through the consistent application of actions, support and practices across all levels of management.

With respect to managing traumatic events specifically, the more confidence individual members of staff have in the sincerity of support that will be offered, the more likely they are to seek and/or accept support, with benefits to both the individual and the organisation in addressing any posttraumatic mental health and wellbeing concerns as early as possible.

Both employers and employees' actions contribute to workplace culture, and both have responsibilities in ensuring best-practice trauma management.

For example, the organisation has a responsibility to ensure best-practice training and procedures are available, and employees have a responsibility to attend training and follow known procedures.

6. Taking a whole of career approach

Purpose: To adequately promote mental health, the needs of employees at all stages of employment should be considered, beginning from recruitment, induction (or initial training), across an employee's career through to when they transition out of the organisation[8].

The whole of career approach to employee wellbeing recommends that rail organisations provide training and interventions tailored to an employee's level of professional experience and career stage.

Employees' support needs can vary depending on where they are in their career lifecycle.

Employees' mental health needs and exposure to risk can also change as they move to different roles or responsibilities within the same organisation (e.g., through change in work area, promotion, or work restrictions as part of an injury management program), or when they transition into or out of the organisation.

During some of these periods, an employee may be more at risk to psychological impacts.

[8]Beyond Blue. (2016). Good Practice Framework for Mental Health and Wellbeing in First Responder Organisations. Melbourne: Beyond Blue.

Moreover, risk for developing mental health difficulties can accumulate over time with repeated exposure to PTEs and other workplace stressors. It is crucial, therefore, that:

- interventions are tailored to an employee's role, level of experience and career stage;
- continuity of care is incorporated into preventative and intervention efforts during these transitions;
- monitoring of mental health and provision of support considers previous PTE exposure and the likelihood of ongoing exposure.

The recruitment phase has unique needs and challenges, so further guidance is provided below on this career stage.

6.1 Recruitment

Recruitment processes aim to identify suitable applicants for a position whilst providing the applicant with the relevant information that enables them to decide about whether the organisation and role is a good match for them.

Whilst meeting the legislative and organisation specific requirements of recruitment, rail organisations should employ a particular approach to recruiting to high trauma risk and safety critical roles.

There are numerous roles within some segments of the rail industry that involve a predictable risk of exposure to PTEs, and organisations should be transparent with potential recruits regarding the potential to be exposed either directly or indirectly to a PTE in this industry.

Position descriptions and job profiles which identify a realistic job environment and clear expectations about the role are one way of increasing transparency.

This transparency is especially important when recruiting to high-risk roles. For example, for personnel interested in becoming a train driver, information about the likely exposure to rail suicide and level crossing accidents should feature in information sessions and/or interviews.

During the recruitment process, a realistic job preview should be provided so that applicants are able to make an informed choice about accepting the job.

In this context, applicants may be advised of factors that increase the risk of adverse mental health responses to trauma, to assist in their consideration of their fit with the role. These factors include[3],[4]:

- poor current psychological wellbeing;
- previous mental health issues;
- poor recovery from a past traumatic experience;
- current life stressors;
- poor social support.

Importantly, these risk factors are not sufficiently reliable to use as selection criteria. Some individuals can carry all these risk factors but still be resilient in the face of trauma, while others, without any of these risk characteristics, can be significantly impacted by trauma.

Furthermore, resilience is not a predictable or fixed attribute, but an interaction between the circumstances, individual variations (e.g., vulnerability, protective mechanisms, coping style) and support following the event [9]. Of these factors, and as noted above, social support following exposure is the strongest predictor of recovery.

When assessing a candidate's suitability for the role, gathering information on proxies for psychological functioning can provide valuable information about how an individual may function at work[8]. Recruitment procedures may therefore include:

- asking about educational background, occupational track record, physical health and other indices of general functioning[10];
- asking about anticipated responses to trauma exposure. People who anticipate excessively high distress may not be suitable but equally, those who anticipate no distress at all may be psychologically unprepared, and equally unsuitable. Moderate distress is to be expected. Also ask about the coping strategies they use when experiencing distress;
- incorporating the relevant behavioural competencies into the recruitment and selection process and assessing at numerous stages during the selection process i.e., during the behavioural interview, tests and reference checking.

[9]Rutter, M. (1987). Psychosocial resilience and protective mechanisms. American journal of orthopsychiatry, 57(3), 316-331.
[10]Wild, J., Greenberg, N., Moulds, M. L., Sharp, M.-L., Fear, N., Harvey, S., Wessely, S., & Bryant, R. A. (2020). Pre-incident training to build resilience in first responders: recommendations on what to and what not to do. Psychiatry, 83(2), 128-142.

7. Pre-incident preparedness

Purpose: Efforts to minimise the impact of workplace trauma need to begin before a traumatic event, with consideration of the workplace culture of the organisation.

PTEs are often infrequent events, however they can be highly distressing for those involved, therefore becoming familiar with skills, resources, policies and procedures prior to an incident is important so that they can be more easily drawn upon in the event of a PTE.

Pre-incident preparedness can be addressed in three stages: (1) development of organisational policies and/or procedures, (2) implementation of policies and/or procedures, and (3) dissemination of education and training.

7.1 Development of organisational policies and/or procedures

The following elements are recommended for inclusion across relevant organisational policies and/or procedures. Relevant documentation should consider:

- clearly defining what is meant by a PTE in the rail industry and which staff are covered by the policy and/or procedures. It is also recommended that organisations conduct an assessment to consider which roles in their organisation are at higher risk of exposure to PTEs, as those in identified high-risk roles require different considerations (see section below on pre-incident preparedness for high-risk roles). Examples of high-risk roles include rail drivers, rail safety workers, incident controllers, investigators and other designated first responders;
- explicitly recognising that PTEs occur, can have a negative impact on mental health and wellbeing, and that every member of the organisation has a role in supporting staff involved;
- reflecting the organisational commitment to providing necessary training in and implementation of best-practice post-incident support (such as PFA)[11]. Acknowledgement at the highest level of the organisation establishes legitimacy, informs the culture and context for post-incident support, and contributes to supportive environment that promotes rather than punishes self-identification of psychological distress.

[11]Hobfoll, S. E., Watson, P., Bell, C. C., Bryant, R. A., Brymer, M. J., Friedman, M. J., Friedman, M., Gersons, B. P., De Jong, J. T., & Layne, C. M. (2007). Five essential elements of immediate and mid–term mass trauma intervention: Empirical evidence. Psychiatry, 70(4), 283-315.

- including definitions of roles and responsibilities for supervisors, managers, specialised peer support staff, peers and welfare personnel including EAPs – for example, indicate who is responsible for monitoring exposed staff, providing support, providing information about self-care, navigating pathways to access further care if needed;
- roles and responsibility of senior leaders, managers and employees would best sit in organisation specific policy and procedures documents. Lack of clear delineation can lead to some aspects being neglected or duplicated. Immediate line supervisors have a key role, as they have prior knowledge of the individual and what else is or has been going on for them. Further, employees are likely to be particularly sensitive to reactions from their immediate supervisor – it is critical that this reaction communicates support and validation rather than criticism for being weak or inadequate;
- including strategies to minimise exposure to trauma. This may include minimising the number of employees exposed to the PTE, minimising exposure to psychological hazards at the incident scene and, where possible, limiting the number of events a particular person is exposed to (i.e., minimise exposure to multiple PTE). The practicalities of this recommendation need to be considered within the unique circumstances of each organisation but may involve, for example, rotating drivers through parts of the network with the highest concentration of critical incidents and ensuring that first responder roles are shared amongst numerous suitably trained people, and;
- including a set of easy-to-read flow charts (or similar) to describe expected organisational response after a PTE, and guide actions for those involved in incident and post-incident response.

7.2 Implementation of policies and/or procedures

Consideration should be given to comprehensive dissemination of the organisation's trauma management related policies and procedures through routine staff communication channels, as well as specially designed promotion initiatives. Implementation across different levels – overall organisation and individual work groups - should be planned.

7.2.1 *Implementation across the organisation*

At an organisational level there needs to be a unified vision of how and why a program aimed at trauma management should be considered and applied.

The stated values and observed actions of senior management are influential in staff confidence that the issue is taken seriously. This assists to develop trust and consistency in the application of programs. When staff expectations are consistently met in a timely manner, trust builds, and the program becomes valued. If applied consistently this approach influences buy in and engagement at multiple levels, creating an expectation of what is available and what should happen for any employee following a PTE.

Slow or inconsistent roll out of initiatives undermines confidence and risks undermining the intent of the program. The use of organisational "champions" who are recognised and admired by staff as advocates of the Framework and related initiatives should be considered.

Rail organisations should also develop and implement an organisation-wide communication plan to increase awareness of the expected PTE post-incident response and mental health support, associated procedures, support services and relevant resources. In addition, organisations need to consider using a range of communication modalities to be inclusive and cater to different employees' needs and preferences.

7.2.2 *Implementation in work groups*

Similarly, the behaviour and attitudes of peers and immediate managers will be influential in staff perceptions of the Framework and related initiatives. The following factors should be considered in implementation of the Framework at a team level:

- ensuring that processes are achievable, practical and easy to access or apply;
- engaging and consulting frontline team members or supervisors in the development of team protocols. This will ensure that protocols are appropriate to the particular circumstances, well understood and "owned" by the team. Involvement in development also ensures that training programs can be incorporated into normal scheduling requirements in such a way to minimise any potential conflict with operational requirements;
- using peers and supervisors who are trained and experienced in providing post-incident support as well as the internal processes for managing events as change leaders with responsibility for mentoring others (refer to the Dissemination of education and training section on recommended training);
- establishing a process of review at the team level that benchmarks current team practice against the Framework intent and operational procedures. This allows for the identification and correction of any practices that have drifted from the agreed approach or reverted to previous practices.

7.3 Dissemination of education and training

Appropriate training and education of employees is critical to the successful implementation of the trauma management practices. Staff with roles and responsibilities within trauma management need to be informed, willing and competent to fulfil their role if there is to be a consistent approach to the management of PTEs and consistent level of support to those impacted, according to need.

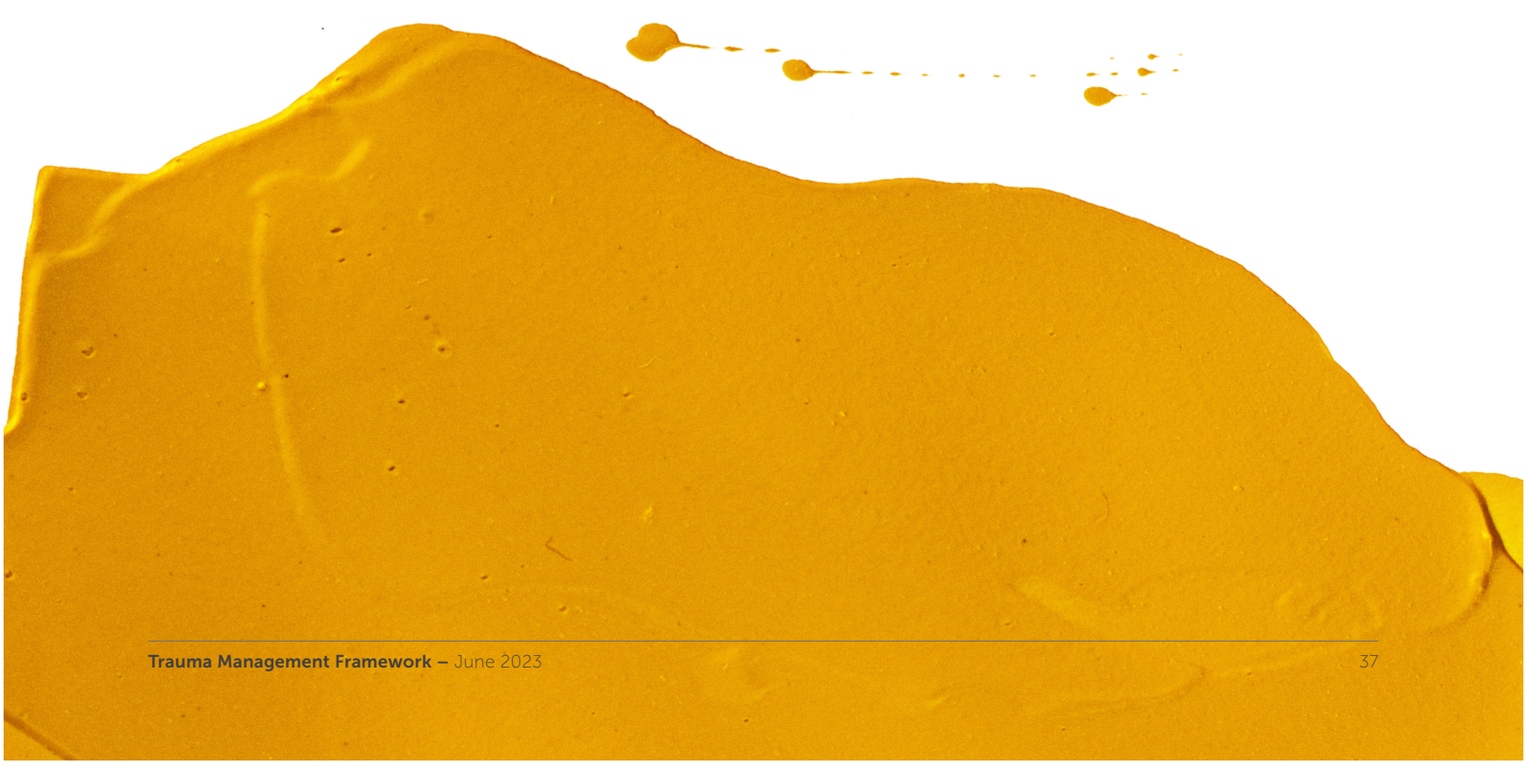
The education and training material should be designed to guide staff towards best-practice in trauma management in a rail environment. Where possible, training about trauma management should be integrated into existing education training initiatives within the organisations, as part of an overall safety and wellbeing strategy and managing psychosocial risk.

Training and education materials should be co-designed with frontline staff, managers, service providers and industry bodies and experts to ensure a range of perspectives and appropriate tailoring of best-practice to the particular operational requirements of the rail organisation.

The training and education material should be delivered by multiple methods, tailored to the needs and preferences of the target group. The latest technologies, including online video materials and mobile phone applications should be explored to their fullest potential. However, the training of those responsible for providing support as part of the trauma management response should also involve hands-on workshops with opportunity to practice skills and receive feedback from facilitators.

The level of training and education given to rail employees will vary, depending upon the level of risk an employee has of experiencing PTE as part of their employment and the level of responsibility an employee would have in managing a PTE.

All training should make clear that staff are not expected to assume the role of a mental health professional, and indeed, that it would be inappropriate for them to do so.



7.3.1 Types of training and education

7.3.2 *Training and education relevant to all staff*

All employees, including senior management, should participate in brief education sessions which could be online, and supplemented by video, web-based or written material.

A whole of organisation top-down approach and multi-episodes of training for staff are more likely to effect lasting behaviour change than single episodes of training at the individual worker level. Training that helps individual workers to prepare for the challenges of their role and achieve mastery of skills during PTEs is beneficial[8].

Therefore, the goals of brief education would be to:

- ensure all employees understand the organisations trauma management related policies and/or procedures and know what the expected organisational response if they were exposed to a PTE;
- enhance perceptions of PFA as supportive and valuable for those exposed to a PTE;
- ensure all employees can provide basic support to themselves and colleagues.

Training should also include education about self-care and coping strategies, as all employees have a level of responsibility for their own wellbeing.

Self-care training should include simple strategies to keep yourself 'match fit' and some examples of healthy (e.g., eating well, exercising regularly, getting sufficient sleep, making time for hobbies) and unhealthy coping strategies (e.g., reliance on alcohol and other drugs, self-medicating with prescription or non-prescription medication, isolating oneself from appropriate social support networks).

As noted above, initial training should be integrated as part of training on usual practices for managing psychosocial risk with opportunities for completing brief refresher training at least every two years. Online would be a suitable modality for the refresher training.

7.3.3 *Training and education specific to line managers and supervisors*

All employees, including senior management, should participate in brief education sessions which could be online, and supplemented by video, web-based or written material.

In addition to the above, specifically tailored training should be provided to those staff who have a direct role in providing support after a PTE. The primary target audience for this training would be line managers and supervisors.

The content of supervisor training could include:

- training in the organisation's management of incident response and related policy and/or procedure documentation, including:
    - » when the system is activated, at what level and following which incidents;
    - » how progress to higher levels of support is determined;
    - » reporting requirements, records, and confidentiality.
- familiarisation with flowchart and/or process guide for providing immediate support/assistance (e.g., removal from incident site as soon as practicable, safe return to depot/work, whether support available upon return to home, etc.);
- training to monitor the wellbeing of staff over time and improve recognition of poor coping strategies or post-event problems;
- training to provide or recommend simple support strategies for distressed staff and suggest further help if necessary, including skills training about having effective post-incident support conversations and follow-up with employees;
- training for managers regarding supporting their own mental health and wellbeing and how the employer and senior leaders can support managers with their self-care.

Such training is intended to promote an organisational environment that encourages help-seeking as required and equips managers with practical skills to support worker mental health[8]. Delivery of this training should ideally be face to face with regular follow-up opportunities for skills practice and discussion. This could be in the format of Community of Practice sessions approximately every 2-3 months or via mentorship in the workplace.

7.3.4 *Training and education specific to peer support roles*

Where organisations have a peer support system (see later section on peer support programs), and the peer supporters have an ongoing role in the support of staff following a PTE, additional training may be appropriate. This could involve training to:

- monitor the wellbeing of staff over time and improve recognition of poor coping strategies or post-event problems;
- provide or recommend simple support strategies for distressed staff and suggest further help if necessary.

Where peer support systems exist or are developed, they should be consistent with international consensus on best-practice in peer support[12,13]. Workers involved in peer support should have opportunities for skills practice and discussion via regular Community of Practice or similar at least every 3 months.

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[12]Creamer, M. C., Varker, T., Bisson, J., Darte, K., Greenberg, N., Lau, W., Moreton, G., O'Donnell, M., Richardson, D., & Ruzek, J. (2012). Guidelines for peer support in high-risk organizations: An international consensus study using the delphi method. Journal of traumatic stress, 25(2), 134-141.

[13]Lawrence-Wood, E., Dell, L., Freijah, I., Madden, K., Sbisa, A., & Sadler, N. (2021). Multi-Agency Peer Support Outcomes of the literature and sector review. Report prepared for DELWP. Phoenix Australia – Centre for Posttraumatic Mental Health: Melbourne.

7.4 Pre-incident preparation for high-risk roles

While any rail industry staff may be exposed to trauma through the course of their career, there are some roles that have greater risk of exposure to a PTE, and these roles at higher risk should be prioritised for inclusion in any pre-incident preparedness program.

As per the pre-incident recommendations, each organisation should identify its high-risk roles such as rail drivers, rail safety workers, incident controllers, investigators and other designated first responders. The purpose of pre-incident preparedness training is to enhance a person's ability to cope with exposure to trauma.

Although there is no evidence consensus to date that pre-incident preparedness training is effective in preventing the development of posttraumatic mental health problems, drawing from the broader literature on effective coping strategies[14], it is prudent to consider methods aimed at increasing psychological preparedness for what may be confronted in the context of a traumatic event, teaching effective coping strategies for managing any immediate psychological distress and ensuring a plan for their own positive coping resources, including the use of social support.

The following content should be considered in training for staff at high risk of trauma exposure:

- information about likelihood of a PTE occurring;
- information about the specific psychosocial hazards that they may be exposed to e.g., experiencing or witnessing assaults, or witnessing critically or fatally injured people and highly distressed individuals;
- information about the nature of potential immediate reactions, as well as potential delayed reactions and effective coping strategies;

- preparing a personal resource kit for looking after their self in the following days (e.g., plan adaptive coping strategies, including social support);
- promoting an expectation of resilience and recovery but providing information about support available from peers, supervisors, management, EAP, professional counselling/treatment servicess;
- providing "post-incident packs" that contain all relevant information (e.g., outline what will happen in the event of a PTE, contact details for peer support, EAP etc.) to staff so that this information is readily available when needed.

Consideration should be given to providing this training at induction with further refresher training at least every two years to reinforce the information provided, self-management strategies and support mechanisms. Employees in high-risk roles should have opportunities to discuss application of practice to support their effective trauma management via regular Community of Practice or peer support.

[14]Michenbaum, D. (1996) Stress inoculation training for coping with stressors. The Clinical Psychologist, 49, 4-7

8. Incident response

Purpose: To ensure that the organisational response to a PTE is consistent with the Framework with respect to minimising exposure to psychosocial hazards. Incident response requires a clear delineation of roles and responsibilities in providing practical and emotional support to affected employees, and providing a level of support appropriate to the needs of the individual.

In the first contact with a person after they have been involved in a PTE, it is vital to communicate organisational support and validation of the experience as potentially traumatic. While there needs to be an established procedure for dealing with incidents, it should be flexible enough to provide individualised support as every incident and every person has different needs.

First responders and managers should be appropriately trained in incident response, and would benefit from having ready access to a toolkit that might include an easy-to-read flowchart that guides their actions in the event of a PTE.

A checklist, based on the flowchart may also be a useful tool in improving alignment with intended procedures. The toolkit should also contain contact details for further support if required (e.g., peer support, EAP) with business cards (or similar) to hand to the worker. The individual and their family should also be provided with written information about the support available and triggers for when a professional assessment is recommended.

When an incident is reported there is an immediate need for an operational response. The first contact with the individual should assist them to fulfil operational requirements, encouraging a focus on the task at hand in a supportive manner.

The reporting of an incident should also trigger the organisation's agreed trauma management response. The response will vary across organisations and scenarios, but below are some key considerations.

- A person should be tasked with the role of dealing with the parties involved; not having to also deal with the incident. Where possible, a member of the immediate work group is best placed to respond as they provide a familiar face and prior knowledge of the individual, which may be a comfort.
- It is imperative that those responding to an incident do so in a timely manner to minimise any ongoing psychological and physical risk to the rail workers involved, and in order to have others take control of the incident to relieve the worker.
- Prior to tasking or enroute, the first responder who is assisting the worker involved should be updated with as many particulars about the incident and worker as possible to help prepare them mentally for what to expect and to minimise any unnecessary questions once on scene.

- Any other employees who will be attending the incident site for operational reasons (e.g., incident controllers, investigators), should also be given as much information as possible so that they are mentally prepared for what they will confront at the scene.
- Where possible, employees asked to attend the site should be given the option to not attend if they do not feel psychologically able to at that time.
- Once on the scene, the first responder should provide comfort and emotional support, whilst helping the person to maintain a practical task-oriented focus.
- Responders should try not to leave the worker alone, but should try to remove the worker in a safe and practical manner away from the scene in order to minimise further exposure unwanted sights, sounds etc.
- It is important to manage direct contact with the employee in order to minimise the number of times they have to re-tell the incident i.e., emergency services, investigators, managers, rail regulators etc.
- Consider whether there are any cultural considerations or procedures that need to be actioned at the scene or with the worker after the incident. For example, in New Zealand it is a tradition that there is a 'TePure' - a blessing used to clear the dynamics of an incident that has occurred such as a fatality - and it usually takes place before the area can be released.
- Once all legal and Enterprise Agreement obligations and relevant operational requirements have been fulfilled, the person should be removed from the incident scene as soon as practical. The worker should be transported back to the appropriate location and assisted in completing final obligatory requirements.
- The supervisor should ensure that the worker is safely transported home following an incident and that they have someone at home or can access a social/family support network if required.
- The employee should be asked if they have a nominated contact person who can be contacted about what has happened and provided with advice on how to support the employee.
- Support should be offered to all who are involved in the incident including responders/ investigators as well as those that may be away from the scene but have experience indirect exposure to details, such as controllers.

9. Post-incident response

Purpose: To assist employees in their transition back to previous functioning at home, in their personal time and at work. The post-incident response should promote the expectation of resilience and recovery, and support for return to normal work routines as soon as possible is also recommended.

A range of flexible internal and external support options that align with the stepped-care approach to mental health support should be available. The level of support provided following a PTE should be matched to the needs and preferences of the individual involved.

Importantly, those who are providing post-incident support should also access their own supervision and support as needed.

9.1 Take a stepped-care approach

The stepped-care approach to supporting mental health is widely used in Australia and internationally.

The model incorporates three levels of increasingly specialised and intensive interventions matched to the individual's needs.

The whole of career approach to employee wellbeing recommends that rail organisations provide training and interventions tailored to an employee's level of professional experience and career stage.

Employees' support needs can vary depending on where they are in their career lifecycle.

It requires organisations to take a systematic approach to monitoring the wellbeing of staff, especially those that are more distressed and/or at heightened risk of poor outcomes, so that decisions can be made about the level of care required.

Figure 3 depicts the stepped-care approach to mental health support after trauma, and Table 2 provides a summary of the strategies, practicalities and care providers for each level of stepped-care.

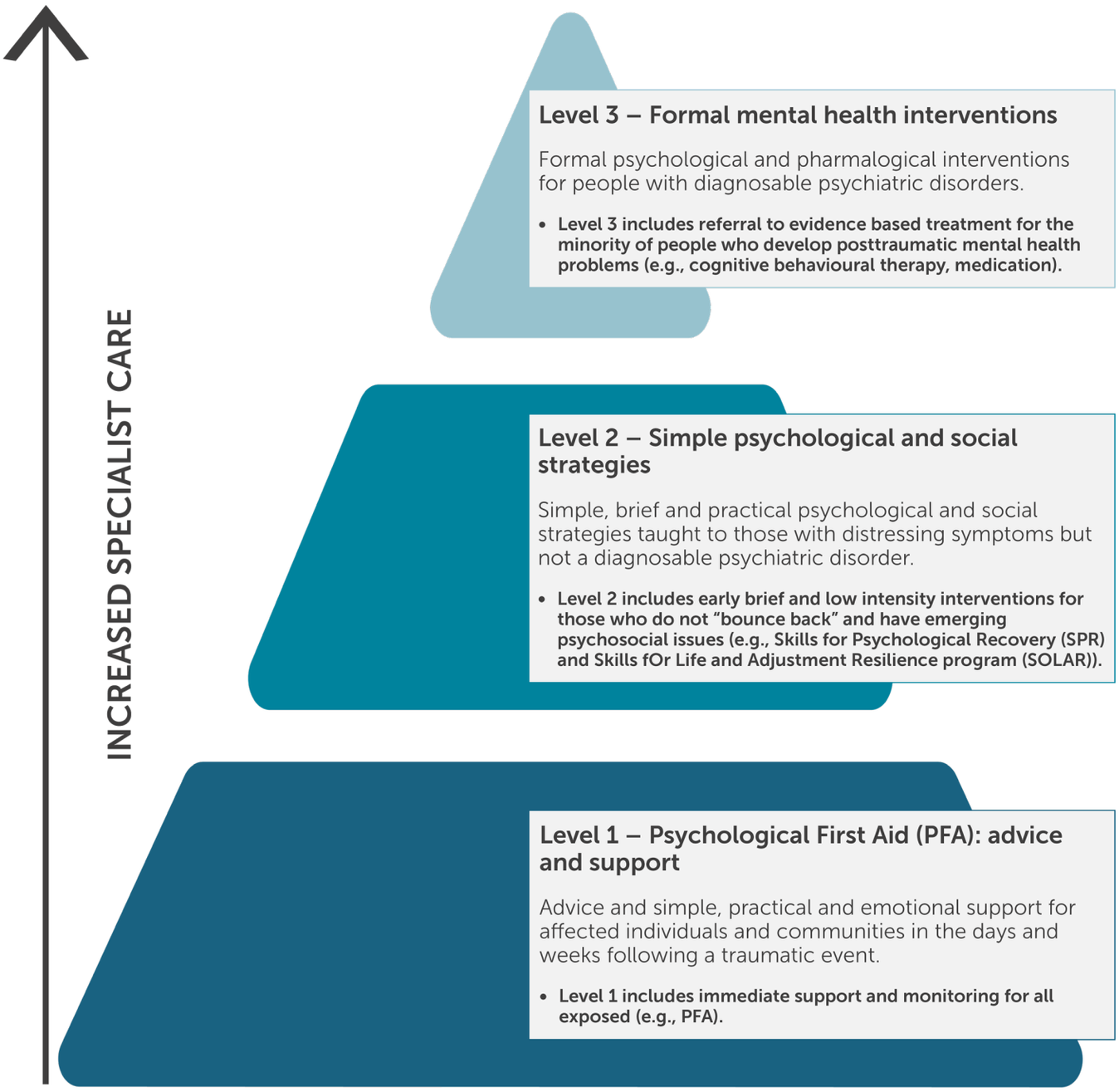

Figure 3. Three levels of the stepped-care approach to supporting mental health

Table 2 highlights the wide range of rail industry roles and external professionals that may be involved in a stepped-care approach; however, family and friends also play a significant role in supporting the mental health and wellbeing after a traumatic event.

Engaging with families (or other significant support individuals) is therefore an important part of best-practice approaches to wellbeing in high-risk organisations.

Moreover, families are often the first to notice changes in the mental health of their loved one.

As such, it would be ideal if they were provided with the necessary knowledge and skills to monitor the mental health and wellbeing of family members, provide support, and facilitate appropriate help-seeking.

Level 1	Level 2	Level 3
Level of severity and timing		
• mild distress • first few weeks	• moderate distress • weeks to months	• mental health disorder • months to years
Example trauma interventions		
• monitoring and support, such as Psychological First Aid (PFA)	• Skills for Psychological Recovery[15] • Skills fOr Life Adjustment and Resilience	• trauma-focussed cognitive behavioural therapy (TF-CBT)
Practicalities		
• informal • flexible	• more formal • 1-6 sessions	• formal • longer term
Appropriate care providers		
• anyone with appropriate training e.g., managers, first responders and/or peer supporters	• primary care, EAPs and other counsellors • others on staff with appropriate training	• mental health providers e.g., EAP providers or external psychologists

Table 2. Summary of the strategies, practicalities, and care providers for each level of stepped-care

9.1.1 *Level 1: Intervention for all – immediate support and monitoring wellbeing over time*

Level 1 of the stepped-care approach can be provided to all impacted by trauma, and generally comprises monitoring, providing information, advice and low intensity emotional support and practical assistance.

Psychological First Aid (PFA) is a widely used Level 1 intervention for supporting an individual in the initial days and weeks following a PTE[9,16].

Of note, PFA is different to Mental Health First Aid (MHFA). MHFA may be useful as part of an organisation's overall approach to workforce mental health and wellbeing, and has been shown to be associated with improved attitudes to mental illness, increased knowledge and self-efficacy[8]. However, there is insufficient evidence for the use of MHFA as a post-trauma intervention (which is the focus of this Framework).

PFA involves a set of principles that can be used to guide the support offered to people following a PTE and is not a structured or standardised intervention. The nature and intensity of the support offered should be determined by the needs of the individual.

PFA aims to: help the person feel safe and secure; encourage the person to ask for and/or accept help and support from colleagues, supervisors/managers, family and friends; reduce immediate stress related reactions; promote helpful coping strategies; and enhance natural resilience.

Training in PFA teaches skills in the following areas, with the expectation that the responder would draw upon the skills as required, depending on the needs of the individual:

- making first contact appropriately;
- attending to immediate practical and safety needs;
- helping calm the person;

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[15]Berkowitz, S., Bryant, R., Brymer, M., Hamblen, J., Jacobs, A., Layne, C., & Watson, P. (2010). Skills for psychological recovery: Field operations guide. Washington (DC): National Center for PTSD.
[16]Psychological First Aid is national and international best-practice in Level 1 trauma management in the initial days and weeks following exposure to a PTE.

- providing reassuring and validating information about the person's reactions;
- encouraging the use of helpful coping strategies;
- connecting with social supports;
- ongoing monitoring and planning follow-up;
- safety needs;
- helping calm the person.

PFA can be delivered by anyone with appropriate training and is ideally provided by people in the person's existing network (e.g., line managers and supervisors).

However, the individual's preferences also need to be considered; some people would rather talk to a mate, co-worker or their partner than a counsellor while others would prefer to talk to a counsellor in the first instance.

In the days and weeks after a PTE, employees should continue to engage in healthy natural coping strategies and try to establish a sense of routine. It is also important to try to avoid unhealthy coping strategies and isolating oneself from their network of support.

Additionally, if the individual's distress does not settle within the initial weeks, their general functioning or behaviour is affected beyond this time, and they or others are concerned about them, they should be referred for further assistance.

Employees should be offered the option to take trauma leave, but it should also be recognised that for some, it would not be helpful to remove them from their routine and workplace environment.

It is recommended that trauma leave is available as a flexible option, rather than a requirement, and is assessed on an individual basis.

9.1.2 *Level 2: Interventions for those who don't bounce back - brief, targeted psychological strategies*

Level 2 interventions are brief, low intensity, and often early interventions for those with emerging mental health issues or who "don't bounce back".

With appropriate training and supervision, Level 2 interventions can be delivered by EAPs and other counsellors, or other key staff members identified by the organisation such as peer supporters. These interventions do not need to be delivered by a mental health professional.

Where external service providers are used, evaluation measures that allow for assessment of the quality of services (at individual case and program levels) should be implemented.

Skills for Psychological Recovery (SPR) and Skills fOr Life Adjustment and Resilience (SOLAR) are two examples of evidence-informed Level 2 interventions.

Skills for Psychological Recovery (SPR)

SPR[13] is an evidence-informed skills-training package that can be used to target wellbeing issues that may be barriers to recovery. The core skill sets are: problem solving; engaging in positive activities; managing upsetting feelings such as anxiety and grief; promoting helpful thinking; building social support; and managing ongoing reactions to the event (e.g., managing reminders). SPR can be delivered by EAPs or other counsellors.

Skills fOr Life Adjustment and Resilience (SOLAR)

The SOLAR[17] program is a brief, manualised, evidence-informed psychosocial program for people experiencing distress and impairment following a PTE. It aims to help the person manage their emotional distress, adjust to life following trauma and prevent them from getting worse down the track. The skills taught in the program are intended to help people manage strong emotions, improve quality of life, improve sleep and increase social support. It is delivered by trained coaches who do not need to have a background in mental health training.

If problems persist after these Level 2 interventions have been delivered, or if the person's symptoms worsen, then the individual should be referred for mental health assessment and treatment (i.e., Level 3).

[17]O'Donnell, M. L., Lau, W., Fredrickson, J., Gibson, K., Bryant, R. A., Bisson, J., Burke, S., Busuttil, W., Coghlan, A., & Creamer, M. (2020). An open label pilot study of a brief psychosocial intervention for disaster and trauma survivors. Frontiers in psychiatry, 11, 483.

9.1.3 *Level 3: Intervention for those with mental health problems – evidence-based treatment*

This is the final and most targeted tier of the stepped-care approach.

Its aim is to facilitate access to individualised support for the minority of employees who go onto develop a mental health disorder such as Acute Stress Disorder (ASD), PTSD, depression, substance misuse and anxiety.

There are evidence-based treatments for these disorders[1], that can involve psychological (e.g., cognitive-behavioural therapy) as well as pharmacological treatments, depending on the unique needs of the individual.

Evidence-based treatment for mental health disorders can be delivered by qualified internal or external mental health practitioners such as psychologists and psychiatrists who have experience with trauma-related mental health difficulties and preferably working with employees in high-risk organisations.

General practitioners should also be involved in the care of people with mental health disorders.

To ensure a high-quality service from external mental health practitioners, practitioners should be required to provide evidence-based treatment and monitor treatment outcomes through agreed evaluation measures.

Additionally, it is important that treating practitioners have relevant cultural understanding and awareness of the workplace context and likely types of trauma in the rail industry.

9.2 Peer support programs

Peer support programs are coordinated programs where members of an organisation provide confidential mental health and wellbeing support to their colleagues. Peer support programs vary across organisations but can include identifying those in need and connecting them to further support and/or providing brief low-level interventions.

With the increased recognition of the significant role that social support plays in mental health and wellbeing, there is a growing trend across high-risk organisations of implementing peer support programs as part of their overall mental health and wellbeing strategy and support options.

Peer support programs, however, can also have a role in post-incident support. The specific role of a peer support program in the post-incident response, if any, should be determined by each organisation.

For organisations that are working towards establishing peer support programs, best-practice considerations should be applied to the following: the goals of peer support; the selection of peer supporters; the role of mental health professionals; training and the role of peer supporters; access to peer supporters and looking after peer supporters, and program evaluation and monitoring[11]. Brief guidance on key issues is provided below.

Common tasks of peer supporters include providing an empathetic, listening ear; providing low level psychological interventions; identifying colleagues who may be at risk to themselves or others; and facilitating pathways and referrals to professional help.

Peer supporters do not generally see "clients" on an ongoing basis and can facilitate pathways to EAP and other mental health supports. When accessing the peer support program, where possible, employees should be able to self-select their peer supporter from a pool of accredited supporters.

Ideally those people selected to be peer supporters should:

- be a member of the target population;
- be someone with considerable experience within the field of work of the target population;
- be respected by his/her peers (colleagues) and;

- undergo an application and selection process prior to appointment that should include interview by a suitably constituted panel.

Once selected, to ensure peer supporters are appropriately skilled, they should:

- be trained in basic skills to fulfil their role such as listening skills, and referral pathways. If they have a role supporting people after a PTE, they should be trained in level 1 trauma-related interventions such as PFA. Peer supporters can potentially deliver Level 2 trauma-related interventions if adequately set up to do so with additional training (such as being a SOLAR coach) and resources, such as time mandate and supervision;
- understand the importance of maintaining confidentiality, except when seeking advice from a mental health professional and/or in cases of risk of harm to self or others;
- meet specific standards in the relevant training before commencing their role;
- participate in on-going training, supervision, review, and accreditation.

In recognition of the potential demands on the individual peer supporter, the program should ensure they:

- are not on call 24 hours a day, and there are clear expectations regarding their availability;
- have access care for themselves from a mental health professional if required to minimise risk of vicarious trauma themselves;
- have access to expert clinical advice and engage in regular peer supervision;
- have an opportunity to participate in evaluation of the peer support program to ensure continuous improvement.

9.3 Support return to work

Purpose: Regardless of the level of stepped-care support provided to workers following exposure to PTEs, the goal is to facilitate a successful return to work for the employee. Research has consistently found that returning to work after trauma or injury is beneficial for the long-term health and wellbeing of employees[18].

It is important to communicate an expectation of recovery and return to work from the outset, with information about the return-to-work process including onsite support, and when needed, assistance with a graduated return to work program or modified duties.

The support and assistance to return to work should commence as soon as possible, usually with the direct line manager of the impacted employee. Managers should convey their attitude of concern and care for the individual and their family, ensuring that their approach is collaborative rather than forced, and tailored to the needs and preferences of the individual. However, setting clear expectations of available support and return to work options allows the employee to take better control of their recovery.

Return to work initiatives may include:

- accessing a mentor program for the employee: providing a fellow colleague who has had similar experiences where appropriate may provide a positive role model and sounding board for an employee who is struggling with return to work;
- graduated Return to Work: where necessary, options for graduated return to work should be offered. When managers have the flexibility to assist employees to return gradually to their normal role, the process can be collaborative and is more likely to lead to a positive outcome for both the individual employee and the organisation.

Return to work requires an employee to be assessed as 'fit for duty' under the Rail Safety National Law (RSNL). Ensuring employers are medically fit to return to their pre-injury role is of particular importance for safety critical workers (cat 1 and 2).

[18]Royal Australasian College of Physicians, T. R. A. c. o. (2010). Realising the Health Benefits of Work: Australasian Faculty of Occupational & Environmental Medicine Position Statement. www.racp.edu.au/index.cfm?objectid=5DDBE561-B6EF-BA29

10. Incident record keeping

Purpose: The purpose of a record keeping system is to ensure standardised and centralised capture of key trauma management related information. This allows for the identification and monitoring of any prospective or current barriers to the successful implementation of the Framework and promotes continuous improvement.

Any record keeping system needs to be reliably, comprehensively and consistently maintained for it to be useful.

It also needs to adhere to confidentiality and other ethical issues regarding informed consent, content obtained and retention of records.

If information capture is poor or not trusted, consideration of methods to improve incident reporting is a worthwhile investment.

However, good record keeping has the potential to allow rail organisations to:

- monitor the incidence and any patterns (e.g., time, location) of potentially traumatic incidents affecting the rail network;
- monitor wellbeing and the cumulative exposure of individual employees;
- monitor the delivery, uptake and timeliness of implementation of post-incident support e.g., PFA, peer support, EAP;
- monitor the impact of post-incident support, for example, through a routine (e.g., annual) survey for those delivering as well as those receiving;
- monitor organisational outcomes of trauma management e.g., morale, return to work, lost workdays, use of trauma leave, WorkCover claims.

Data can be collected for the purposes of individual, organisational and national level insights.

Insights that can be gained at each of these levels are described on the next page.

Individual level data insights

The data collected could be used to at an individual level to:

- identify individuals who experience multiple PTEs in a short time frame, prompting supervisors to make a point of checking on their wellbeing;
- provide an alert/trigger mechanism if an employee is unfit for duty to ensure adequate individual support is provided.

Organisational level data insights

Incident data could be used at an organisational level to:

- provide an accurate and reliable reporting solution for organisations in the management of trauma, the impact on its employees, and associated costs;
- gain greater understanding of the effectiveness of services, programs, initiatives, communication and marketing methods to enhance implementation and delivery to employees;
- provide reliable evaluation to assess against key performance indicators;
- through deidentified group data, identify hotspots, clusters, trends across the business, organisation, regions and states to enhance the capacity to provide trauma support programs and customised, preventative solutions.

National level data insights

Rail industry organisations could consider collectively deciding on a subset of this information that could be appropriately shared in a national data management system.

A national system would improve the rail industry's overall capacity to capture, identify, assess, and analyse the risks and impacts these events have on employees and organisations. Shared data could improve the rail industry's efficiency and effectiveness in providing relevant services, programs and initiatives across rail organisations through pooling shared experience and evidence.

Data could be used at a national level to:

- create national statistical reports allowing individual rail organisations to benchmark their data against national averages;
- support collaboration between organisations in providing best-practice support, allowing each organisation to learn from the experience of others and share potential solutions
- Identify shared issues (e.g., hotspots, clusters, trends) across the organisations that may lead to common solutions;
- determine the appropriate allocation of resources.

11. Review, monitoring, evaluation and continuous improvement

Purpose: To provide a vehicle for continuous improvement by following a structured process to identify highlights and opportunities associated with the Framework.

Implementing a systematic approach to monitoring and evaluating organisational trauma management related initiatives is considered best-practice.

This process facilitates the identification of any prospective or current barriers to the successful implementation of the strategy and promotes continuous improvement.

Moreover, organisations that routinely evaluate their approach to employee wellbeing and have continuous improvement processes are more likely to provide evidence-based psychosocial supports.

Key organisational facilitators for continuous improvement include:

- collecting and utilising adequate data to inform the organisation's approach to improving and promoting employee mental health and wellbeing;
- leadership commitment to regular reviews of mental health prevention and support strategies informed by data collection framework, staff consultations and best-practice;
- committing to a whole-of-organisation and systematic approach to evaluation;
- developing an evaluation Framework to assess the implementation of mental health and wellbeing policies and practices.

A two-tiered approach is recommended, dealing with individual case by case reviews (Tier 1), and a higher-level strategic approach (Tier 2) that provides a systemic assessment of the overall Framework and each of its elements.

11.1 Tier 1 and Tier 2

Tier 1	Tier 2
An organisational system should be established that, following individual events/cases, prompts a review of effectiveness of the service provided to the stakeholders involved. Confidentiality should be maintained in upward reporting of the results of Tier 1 reviews.	A review of the organisation's implementation of the *Trauma Management Framework* should be undertaken by each organisation on a regular basis, ideally annually.
A template could be used to facilitate this process and as a minimum will have the following components: • direct feedback from the individual(s) for whom the support was initiated and feedback from other involved parties (e.g., first responders, leaders etc), including an assessment and commentary, where applicable, on the following: » appropriate level of support; » timely; » professional; » individualised; » peer support; » on-going support; » pressure from the organisation (to return to work etc.); » feedback on the performance /quality of provider; » overall perception of service provided. • a timely process for providing feedback to the staff involved in the post-incident response, based on feedback from the individual who exposed to a PTE and other parties from whom feedback was sought.	**The organisation can determine the most appropriate methodology and personnel involvement but as a minimum the review should include:** • a review of all elements of the *Trauma Management Framework*. For each element, have a series of prompts that represents best-practice, thus allowing for a gap analysis of the organisation's performance against these criteria for the selected review period; • the identification of any trends based on de-identified data collated from Tier 1 feedback; • a prioritised action plan based on the identification of appropriate remedial actions where deficiencies have been identified and sharing learnings / strategies where areas of excellence have been identified.

11.2 Accountabilities and Review of the content of the *Trauma Management Framework*

It is critical that all personnel involved in the review process provide an honest assessment based on their experiences.

This is more likely to be achieved with a shared understanding of the reason for the review and how the information will be used. Specifically, it should be independent of any performance appraisal processes.

The organisation should designate a role whose stated responsibilities include co-ordinating the Tier 1 review process and ensure this process is conducted in a confidential manner.

The organisation's leadership will ensure systems are in place to prompt the Tier 2 review and assign resources necessary to complete the review and then to implement any actions leading from the review.

Based on the rate of progress in this field, a comprehensive review of the content of the T*rauma Management Framework* is recommended in 5 years.

In the interim, rail organisations should keep abreast of new developments and review the Framework in an ongoing way against best-practice.


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Definitions

Term	Definition
Acute Stress Disorder (ASD)	Acute Stress Disorder is classified as significant distress and/or impairment in social, occupational or other important areas of functioning after an individual has been exposed to a traumatic event. ASD is diagnosable when an acute stress response lasts longer than two days following a traumatic event, but no longer than a month.
Critical Incident (CI)	Critical incidents in the rail industry are defined as any event or series of events that is sudden, overwhelming, threatening or protracted. This may be an assault, threats, severe injury, death e.g., suicides on railway, near misses or other serious railway incidents. Refer to your organisation's documentation for its specific definition of a critical incident.
Cumulative trauma	Cumulative effects of multiple exposures to traumatic events that can be repeated instances of the same type of trauma or multiple different types of traumatic events.
Employee Assistance Program (EAP)	An employee assistance program is an employee benefit program that assists employees with personal problems and/or work-related problems that may impact their job performance, health, mental and emotional wellbeing.
High-risk roles	Roles that are more likely to expose employees to direct or indirect trauma exposure, including on a repeated basis. Each organisation should articulate its high-risk roles, but they may include drivers, investigators and first responders.
Lost Time Injury Frequency Rate (LTIFR)	Lost Time Injury Frequency Rate refers to the number of lost time injuries occurring in a workplace per one million hours worked.
Mental Health First Aid (MHFA)	Mental Health First Aid is a skills based, early-intervention program to mobilise and empower people with the knowledge and confidence to recognise, connect and respond to someone experiencing a general mental health problem or mental health crisis. It is not a best-practice approach for post-incident support.
Operational Debriefing	A group process undertaken in high-risk industries to review a particular operation or activity. The aim of operational debriefing is to review the events and processes of the operation and to apply the lessons learnt to future events. Operational debriefing is considered good practice in high-risk industries as a method of improving service quality.
Operational stressors	Role-related stressors that are not traumatic on their own but can contribute to the impacts of a PTE e.g., remote work and shift work.
Organisational stressors	Stressors related to organisational processes and culture. This can include poor leadership or unsupportive management styles, poor team functioning, workplace culture, organisational change and unbalanced workloads.
Peer support	Peer support programs are coordinated programs where members of an organisation provide mental health and wellbeing support to their colleagues. This is a voluntary role, unpaid and in addition to the standard duties of their role. Peer support programs vary across organisations; however they can include identifying those in need and connecting them to further support and/or providing brief low level interventions such as Psychological First Aid.

Term	Definition
Posttraumatic Stress Disorder (PTSD)	Posttraumatic Stress Disorder can develop after exposure to a PTE. This could be in response to any threat, actual or perceived, to the life or physical safety of the individual, their loved ones or those around them. Some examples include witnessing death or severe injury, war, sexual or physical assault, natural disasters, accidents, and terrorism. Symptoms last for more than four weeks duration.
Posttraumatic Stress Injury (PTSI)	Posttraumatic Stress Injury is a mental health condition that can develop in response to exposure to a potentially traumatic event. The term is sometimes used interchangeably with PTSD and is preferred by some as there can be less stigma viewing it as an 'injury' rather than a 'disorder'. PTSD is the most commonly used term, and the official diagnosis name, so is used in this Framework.
Potentially traumatic event (PTE)	Exposure to an actual or threatened event or situation (for example, death, serious injury, or sexual violence) that has the potential to create a significant risk of substantial or serious harm and/or trauma to the physical or mental health, safety or wellbeing of the individuals who were exposed to it. A PTE (encompasses a critical incident) can include: • directly experiencing the traumatic event(s); • witnessing in person, the events(s) as it occurred; • learning that the traumatic events occurred to a close family member or close friend (i.e., this would include a close work colleague); • repeated or extreme exposure to adverse details of the traumatic event(s) through a work role.
Psychological Debriefing	Psychological debriefing is no longer considered best-practice in the aftermath of a PTE and is not recommended in this Framework. During psychological debriefing individuals are asked to provide detailed facts about their traumatic experience, their thoughts, reactions and symptoms before being provided with psychoeducation about symptoms and how to deal with them.
Psychological First Aid (PFA)	An evidence-informed flexible approach that involves providing early practical and emotional support to a person(s) who has experienced a very stressful or traumatic event. PFA seeks to reduce initial distress, address basic needs (for example, comfort, information, practical and emotional needs), promote adaptive coping (for example, assist with problem-solving), and encourage engagement with existing social supports and professional services as appropriate.
Psychosocial hazard	Psychosocial hazards are factors in the design or management of work that increase the risk of work-related stress and can lead to psychological or physical harm. Examples of psychosocial hazards include exposure to a PTE or high job demands.
Resilience	Resilience refers to the ability to bounce back from adversities. Resilience doesn't mean not being negatively impacted by a traumatic experience, but rather the ability to return to previous functioning and persevere through adversity.
Rail staff/employee	Any person employed by an organisation working in the rail supply chain, this includes operational roles, infrastructure and construction upon light rail, heavy passenger, freight and heavy haulage.

Term	Definition
Rail safety worker	An employee, contractor, subcontractor, or volunteer undertaking rail safety work on a a heavy or light railway system as defined by current rail safety laws and regulations.
Safety critical workers	These are workers whose sudden incapacity could lead directly to a serious incident affecting the public or the rail network. Their vigilance and attentiveness to their job is crucial. These workers require health assessments to ensure ill-health does not affect their vigilance and attentiveness to the job, and therefore the safety of the public or the rail network. Safety Critical Workers' tasks are distinguished from tasks that affect only individual worker safety.
Skills for Psychological Recovery (SPR)	Skills for Psychological Recovery is an evidence-informed skills-training package that can be used to target wellbeing issues that may be barriers to recovery. The core skill sets are: problem solving; engaging in positive activities; managing upsetting feelings such as anxiety and grief; promoting helpful thinking; building social support; and managing ongoing reactions to the event. SPR can be delivered by trained non mental health practitioners, or EAPs or other counsellors.
Skills fOR Life Adjustment and Resilience Program (SOLAR)	The Skills fOR Life Adjustment and Resilience Program is a brief, five-session, skills-based program that aims to promote wellbeing and can be delivered by trained non mental health practitioners called Coaches (e.g., community leaders, peer supporters, health care workers, and lay people).
Stepped-care	A stepped-care approach to mental health support refers to a process where different levels of mental health interventions are matched to individual needs with 1) universal interventions made available to all employees to prevent or minimise the impacts of exposure to PTEs; 2) early low intensity support for employees with emerging mental health issues; and 3) specialist mental health and return to work support for those who develop more entrenched mental health issues.
Total recordable injury frequency rate (TRIFR)	The Total Recordable Injury Frequency Rate (TRIFR) is the number of injuries requiring medical treatment per million hours worked within an organisation.
Trauma-informed Care (TIC)	Refers to an approach that promotes wellbeing at both an individual an organisational level through understanding and considering the potential impacts of trauma and how it may influence an individual's presentation, and how to best support their recovery. It involves ensuring that the policies, procedures and environments in a workplace are mindful of people's trauma histories and support the physical, psychological and emotional safety of its workforce.
Trauma Leave	Paid leave for rail workers impacted by attendance at a PTE or impact following indirect trauma exposure. Trauma leave provisions should include industrial relations and human resource (HR) considerations, and any period of trauma leave should not be attributed to standard leave entitlements. Refer to your organisation's Enterprise/Industrial Agreement for guidance on trauma leave provisions, how to access them and HR considerations.
Vicarious trauma	Refers to a range of cumulative and harmful symptoms that develop in response to indirect exposure to other people's traumatic experiences, including symptoms similar to other post-trauma responses such as PTSD or depression. This includes being affected by hearing about their traumatic experiences and/or being exposed to distress and risks experienced by people with a history of trauma. Vicarious trauma can significantly impact on mental health, social, and occupational functioning.

References

Berkowitz, S., Bryant, R., Brymer, M., Hamblen, J., Jacobs, A., Layne, C., & Watson, P. (2010). Skills for psychological recovery: Field operations guide. Washington (DC): National Center for PTSD.

Beyond Blue. (2016). Good Practice Framework for Mental Health and Wellbeing in First Responder Organisations. Melbourne: Beyond Blue.

Bonanno, G. A. (2004). Loss, trauma, and human resilience: have we underestimated the human capacity to thrive after extremely aversive events? American psychologist, 59(1), 20.

Brewin, C. R., Andrews, B., & Valentine, J. D. (2000). Meta-analysis of risk factors for posttraumatic stress disorder in trauma-exposed adults. Journal of consulting and clinical psychology, 68(5), 748.

Creamer, M. C., Varker, T., Bisson, J., Darte, K., Greenberg, N., Lau, W., Moreton, G., O'Donnell, M., Richardson, D., & Ruzek, J. (2012). Guidelines for peer support in high-risk organizations: An international consensus study using the delphi method. Journal of traumatic stress, 25(2), 134-141.

Hart, P. M., & Cotton, P. (2003). Conventional wisdom is often misleading: Police stress within an organisational health Framework. In Occupational stress in the service professions (pp. 117-156). CRC Press.

Hobfoll, S. E., Watson, P., Bell, C. C., Bryant, R. A., Brymer, M. J., Friedman, M. J., Friedman, M., Gersons, B. P., De Jong, J. T., & Layne, C. M. (2007). Five essential elements of immediate and mid–term mass trauma intervention: Empirical evidence. Psychiatry, 70(4), 283-315.

Lawrence-Wood, E., Dell, L., Freijah, I., Madden, K., Sbisa, A., & Sadler, N. (2021). Multi-Agency Peer Support Outcomes of the literature and sector review. Report prepared for DELWP. Phoenix Australia – Centre for Posttraumatic Mental Health: Melbourne.

Michenbaum, D. (1996) Stress inoculation training for coping with stressors. The Clinical Psychologist, 49, 4-7

O'Donnell, M. L., Lau, W., Fredrickson, J., Gibson, K., Bryant, R. A., Bisson, J., Burke, S., Busuttil, W., Coghlan, A., & Creamer, M. (2020). An open label pilot study of a brief psychosocial intervention for disaster and trauma survivors. Frontiers in psychiatry, 11, 483.

Ozer, E. J., Best, S. R., Lipsey, T. L., & Weiss, D. S. (2003). Predictors of posttraumatic stress disorder and symptoms in adults: a meta-analysis. Psychological bulletin, 129(1), 52.

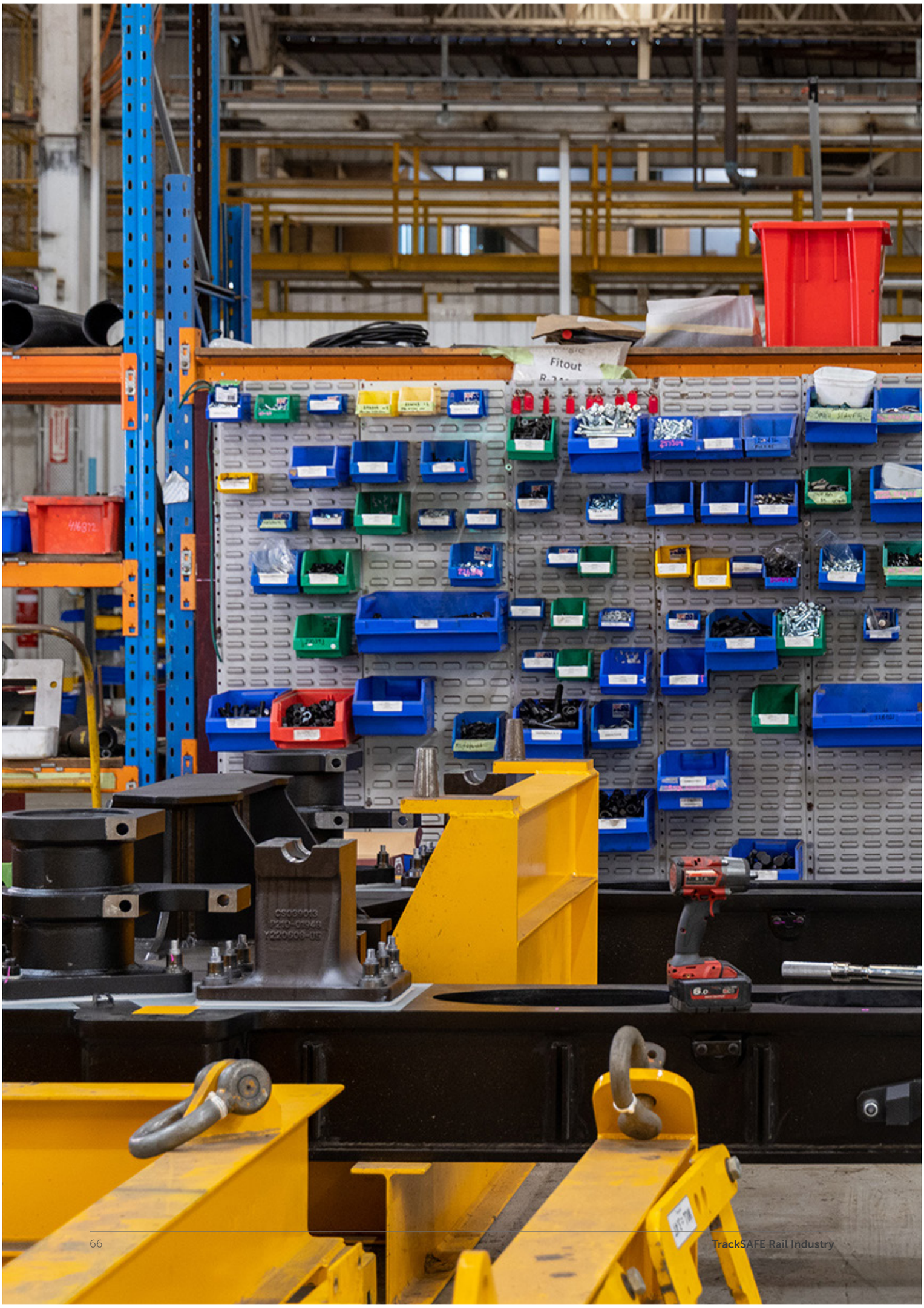
Phoenix Australia. (2020). Australian Guidelines for the Prevention and Treatment of Acute Stress Disorder, Posttraumatic Stress Disorder and Complex PTSD. www.phoenixaustralia.org/australian-guidelines-for-ptsd/

Physicians, T. R. A. c. o. (2010). Realising the Health Benefits of Work: Australasian Faculty of Occupational & Environmental Medicine Position Statement. www.racp.edu.au/index.cfm?objectid=5DDBE561-B6EF-BA29

Rutter, M. (1987). Psychosocial resilience and protective mechanisms. American journal of orthopsychiatry, 57(3), 316-331.

Safe Work Australia. (2022). Managing Health and Safety, Mental Health: Psychosocial Hazards

Wild, J., Greenberg, N., Moulds, M. L., Sharp, M.-L., Fear, N., Harvey, S., Wessely, S., & Bryant, R. A. (2020). Pre-incident training to build resilience in first responders: recommendations on what to and what not to do. Psychiatry, 83(2), 128-142.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