LEGISLATIVE COUNCIL

SELECT COMMITTEE ON SUPPORT AND MENTAL HEALTH SERVICES FOR POLICE

Old Parliament House Chamber, Old Parliament House

Wednesday, 16 October 2024 at 11:10am

BY AUTHORITY OF THE LEGISLATIVE COUNCIL

WITNESS

MEMBERS:

Hon. L.A. Henderson MLC (Chairperson)
Hon. E.S. Bourke MLC
Hon. S.L. Game MLC
Hon. D.G.E. Hood MLC

WITNESS:

SARGENT, JASON, Director and Senior Mental Health Clinician, Healthy Mind International

483 The CHAIRPERSON: Welcome to the meeting. The Legislative Council has given the authority for this committee to hold public meetings. A transcript of your evidence today will be forwarded to you for your examination for any clerical corrections. The uncorrected transcript of your evidence today will be published immediately upon receipt from Hansard, but the corrected transcript once received from you will replace the uncorrected transcript.

I advise that your evidence today is being broadcast via the Parliament of South Australia website. Should you wish at any time to present confidential evidence to the committee, please indicate and the committee will consider your request. Parliamentary privilege is accorded to all evidence presented to a select committee; however, witnesses should be aware that privilege does not extend to statements made outside of this meeting. All persons, including members of the media, are reminded that the same rules apply as in the reporting of parliament.

Thank you very much for appearing before us this morning. My name is Laura Henderson. I am the Chair of this committee. To my left, I have the Hon. Emily Bourke and the Hon. Sarah Game. We will open up to you for an opening statement, and then we might have a couple of questions from committee members.

Mr SARGENT: Thank you for allowing me to present before the committee this morning. My name is Jason Sargent. I am a mental health clinician, a registered provider with South Australia Police and also with Medicare, DVA and a number of other organisations. I have been treating members of the South Australian police force for coming up to nearly three years. Some are referred to me directly from the South Australia Police within their injury management/internal health area. A number of the officers I see, however, refuse to go through that section and, by way of speaking with other colleagues, seek my clinical services under a Medicare mental health plan through their GP.

I will just enlighten you: I'm formerly a member of the Australian Federal Police and also actually have post-traumatic stress disorder, which led me into changing careers. Being a lived experience practitioner I have a different level of engagement and knowledge in relation to police and emergency service mental health.

The majority of officers who present to me present with classic, what we would say, trauma presentations and post-trauma presentations from jobs that they have attended. Also, from the records that I have taken during my sessions, a lot of the presentations centre around they have exacerbations in the way that their mental health is either being treated or how they are being received when they have identified a mental health issue by their superiors and/or other members in general within SAPOL.

My overall view after discussion with many of the officers is that their general words are 'We have no faith in SAPOL's ability to assist us with our mental health,' hence why they go outside and don't want SAPOL to be notified that they've sought mental health assistance. Stigmatisation being dealt with punitively because they either aren't able to attend work, need time off or have identified that they have a mental health condition or they're not feeling up to the task mentally is a common statement that I hear, and their observations of other members who have

come forward and how they've been negatively treated has also been a great catalyst for them to basically not want to say anything.

The majority of officers I see, I would say at least 90 per cent, post attending critical incidents have either had no post incident mental heath debriefing or they have received between several hours later, up to days later, a cursory phone call from the SAPOL EAP which they have found completely ineffective, and the EAP person they're speaking to has no knowledge or understanding of trauma or police work. Having formerly been an EAP provider, the issue is that EAPs can't refer on further without going through the employer, hence a lot of staff don't want to engage with the EAP because they want their privacy protected.

Also, some officers, in fact most of the officers I have worked with, post critical incidents, have simply been told 'Fill out your paperwork and get back on the road because there are jobs to do.' Very few, if any, are actually stood down and told to take leave, from what I have been told by them. There have also been cases of senior officers making poorly timed statements. I have had officers off on leave with senior officers, on one occasion, ringing the person who was on dedicated mental health leave to ask him how he was enjoying his holiday, which caused an exacerbation and showed no care for the officer's mental health or wellbeing.

I have also had a former officer who recently left SAPOL, who at one time worked in the health management area, and post working in there his faith was completely eroded when he saw senior officers coming in and demanding the medical files of police officers and stating that they would then manage the case and would take the file, which is in complete contravention of the Privacy Act, and the medical privacy, which just erodes any level of faith that officers have in that their medical information is going to be private and not put out and not be accessed by their team leaders or their senior officers. That medical information should be held, as it is in my practice and every other medical practice, sacrosanct and not open for anyone outside of that area.

I have also had clients where their police medical records have had statements written in there of diagnoses that they have never been diagnosed with. One was an officer who was written down in his paperwork as having bipolar disorder. I worked with his psychiatrist, and his psychiatrist formally wrote to SAPOL to say that he has not been diagnosed with this, this is incorrect—the stigma he was facing in his role.

I have had other officers where it said that they have had alcohol abuse and that they are an alcoholic was written in their files when that was not the case. They may have had a substance misuse issue at one time, but they have then recovered from that. I have had an occasion to require, as we do in the medical and clinical field, a patient to sign an authority to release their medical information to another clinician—myself—and I have received back statements from SAPOL saying, 'We can't release the officer's medical file because there are administrative issues written in there.' That is administrative issues as in disciplinary issues, written in medical reports. The two should not be crossed.

I have also had officers who have been denied access to their own medical records and have had to file freedom of information requests to obtain their medical records. This is quite demeaning to officers. If you have officers who have no faith in either the privacy of their medical information or people within the organisation putting down statements within their medical records that either have not been diagnosed or have no basis or validity, that goes to undermine further their confidence in SAPOL supporting them from a mental health perspective.

I had one incident, and I just spoke with this former officer today, where he and a colleague attended a child who had drowned. They attended and tried to revive the child. They were unsuccessful. They were told to do their paperwork and go back on the road. At no time were they contacted by EAP or any other mental health clinician within SAPOL. They were also put up for a commendation. They were then told directly by a superintendent, 'You don't deserve a commendation. You're just doing your job.' That officer is now constantly one of my patients.

It seems, from my professional view, that the EAP organisation is something that SAPOL officers have told me they vehemently avoid at all costs, and the majority of them are seeking their own private mental health plans through their GPs, especially also in relation to being prescribed medication. One of the major issues that comes up in a lot of discussions with my patients is that they don't want SAPOL to know that they may be on an antidepressant or an anxiety-based

medication, because they feel they will be penalised or stigmatised and passed over for promotions and other sorts of benefits in their role.

In relation to contact from the health section towards me as a clinician when dealing with SAPOL officers, again there seems to be quite a stonewall. It is very rare that we receive, especially if it is a return to work—I think I have received three communications in the last three years from SAPOL asking how an officer is progressing. Most of the time when I have, the comment is, 'When do you think they'll be back to work?'—there is no asking about how their mental health is—and comments like, 'When do you think they'll be over their PTSD?' which is not something you get over. Having it myself, it's a lifelong condition.

I think there needs to be major re-education in relation to mental health in SAPOL for all rank and file and officers. It has been even to the point of having one person in the return-to-work area—and an inspector—say to me, 'When are they coming back to work, because we need to fill the position?' with no discussion of how the member is travelling from a mental health perspective.

I think overall there is a fear among SAPOL members that if they speak up it's going to go very badly for them. I think the mental health of South Australian police officers generally is very poor. Even officers I speak to who are not patients, as soon as they understand that I see SAPOL officers, will open up and say, 'I've got this. I would never say anything. I have no trust or faith in SAPOL.' And a lot of them are saying, 'They're not supporting me. I'm going to leave,' which is a shame, because the government spends so much money training these people, but we are not supporting these people in the critical time when they need it.

484 The CHAIRPERSON: Is that your opening statement?

Mr SARGENT: Yes.

485 The CHAIRPERSON: I just have a couple of questions, then I will open it up to my colleagues.

Mr SARGENT: Please.

486 The CHAIRPERSON: You've referred to SAPOL officers typically not wanting to use or refusing to use the EAS and the EAP program that is provided, and you have mentioned that they don't have faith in the services that are provided. Why is it that officers are feeling that way? Is it concerns around confidentiality, or is it the services themselves that are provided and a perception that perhaps they are inadequate to deal with the complexities that officers are dealing with?

Mr SARGENT: Both. With the EAP services, before any EAP can actually write a report or can refer on the patient they actually need to go back through to the organisation to get the management approval, so therefore there is a bit of a disconnect in relation to privacy. That is the first point.

The second point is that the majority of officers I have spoken to feel, if they have used the EAP service, that the person on the end of the phone is going through the motions; that they have no knowledge of people who work in trauma situations, especially emergency services situations; and that they get no beneficial direction apart from what we term narrative therapy. Narrative therapy is talking therapy, and essentially it is asking, 'How are you feeling? Are you doing okay?' It is basic, general questions: 'Do you want to harm yourself? Are you feeling like taking any actions that might hurt yourself?' and there is almost a time limit on the conversation. So they just feel completely underwhelmed by the service they are being provided.

487 The CHAIRPERSON: So if you had any recommendations for the committee as to how this could be addressed, how could this service be improved?

Mr SARGENT: First of all, having worn a uniform myself and now being a clinician, I think SAPOL would be wise to establish an actual panel of providers in South Australia that can respond either on site, post critical incident, to properly conduct a mental-health-process debrief of officers—take them out of the critical phase—or that are able to be phoned and actually take the officers through a de-escalation, a decompression, with a direct meeting within 24 hours or later that day. It is highly critical that officers get immediate engagement, but the clinicians need to be trained in trauma.

488 The CHAIRPERSON: Do you believe that there are enough psychologists and psychiatrists who are trained to deal with the kind of trauma that police officers—and probably frontline workers more broadly—are seeing in their line of work and some of the more complex issues and are able to build that rapport with police officers?

Mr SARGENT: I think there's a lacking number in South Australia. I am classed as an accredited mental health social worker, which means I provide under Medicare, DVA, and ReturnToWorkSA etc., focused psychological therapies, which is exactly the same process that a psychologist follows, we just don't do assessments. I have many colleagues who are psychologists and many of them want nothing to do with trauma. There are not enough trained clinical mental health therapists to provide that mental health critical implementation. That's one of the reasons why that's a major focus with my business and my clinic, because I see too many officers falling through.

489 The Hon. E.S. BOURKE: Just on that point, we see this come up quite a fair bit in the allied health world. Is there another way of providing training? You mentioned this could be a panel. You mentioned before about your lived experience and I'm guessing that's helped a lot with building that trust with people coming to see you—

Mr SARGENT: Yes.

490 The Hon. E.S. BOURKE: —but also knowing a little bit more about their work life and what they're actually going through. Do you think in that panel there could be people that are peer-to-peer support as well, so it's not going straight into mental health? It might start with someone who has more experience and knowledge in the mental health space, but also training up other people who may be retired and who want to give back to the service. Do you think there are other roles available outside the allied health professional that could be on such a panel?

Mr SARGENT: There is, but it's a fine line because we don't want to take officers who have served a number of years and have their own trauma and haven't dealt with that, trying to then provide management and de-escalation trauma services to those officers. I think it does have sound merit. The trainer would have to be very, very meticulous and it's not a one-week course.

I have seen peer-to-peer actions. I also provide services to SA Ambulance. They have a peer-to-peer program and it's woefully inadequate. You might have someone who, with all good intentions, has been in the force or the service for two years and they want to be a peer support, and they are phoning someone who has been in the game for 30 years and there is just a complete disconnect, so it needs to be very well managed. Can it work? Absolutely, but there needs to be a very solid and long-term training process to understand how to navigate and work with someone who is presenting with mental health issues.

491 The Hon. E.S. BOURKE: Are you able to suggest any other professions where they could be upskilled in this space to support trauma?

Mr SARGENT: We have psychiatrists, of course; we have psychologists. We have, like myself, accredited mental health social workers. The other option is that you have mental health nurses, who have actual post-graduate mental health training. There are people who are qualified as counsellors. The difference with counsellors is that the training is not in the same direction as all the aforementioned and that's why we are classed as therapists and not counsellors. We do provide some counselling, but it's a therapeutic process that we all provide.

492 The Hon. E.S. BOURKE: Do you know if there is any micro-credential related to trauma that people would go through?

Mr SARGENT: Absolutely, there would be micro-credentials. Flinders University hypothetically, for instance, would be more than happy to create a micro-credential. There are existing micro-credentials out there.

I think it would need to be managed by external panel members because what we don't want is ticking boxes. We want an actual sound dedicated mental health support element if it's going to be within SAPOL with SAPOL officers, but I think an external panel of providers is okay. I understand that there are always budgetary constraints, but if you had 10 mental health providers and they went onto a roster, you would see over time that, if they were engaged post critical incidents, the level of police officers exiting SAPOL due to mental health issues would greatly diminish.

There is also another element I would like to present. Japan at one stage had the largest number of workplace suicides in the world. In 2014, the Japanese government introduced what they call a mandatory yearly mental health assessment for every company that employed over 50 employees. Every employee was to do a questionnaire on their mental health. It was assessed independently, and if red flags came out, they were then automatically taken offline and referred for mental health assessment. This reduced the level of suicides in the workplace in Japan down to 14 per cent.

So a proactive measure like that where every SAPOL employee, whether they are uniformed or not uniformed, is provided a yearly mental health assessment, in my professional view, both as a clinician and having researched, would have the potential to greatly reduce the loss of well-trained officers out of SAPOL. It would also build a greater level of confidence and support in the organisation between the hierarchy and the officers themselves.

493 The Hon. S.L. GAME: Thanks very much for your opening statement. I thought you created a really clear depiction of the situation and the gaps and why it's so tricky. Can I just ask: how long were you in the police force for?

Mr SARGENT: I joined the Australian Protective Service as a counterterrorism officer in 2002, and we were reassumed by the Federal Police and the protection division. I left there in October 2006. In that time, I had served counterterrorism first response at the airports, diplomatic protection, Nauru for the asylum seekers, and first deployment to Solomon Islands in 2003 post when we were sent in for operation RAMSI to restore law and order. I came back in 2003 and was diagnosed with PTSD under DVA in 2014, so I had suffered quite a long time, and I don't want other officers to be suffering.

494 The Hon. S.L. GAME: Thank you so much. One aspect that was clear, and I'm not exactly sure how you fix it, is that it seems to me that regardless of the service, the training or the level of qualification that somebody has, there needs to be a level of empathy and compassion in that delivery and genuine interest and concern to create that engagement, doesn't there?

Mr SARGENT: Absolutely.

495 The Hon. S.L. GAME: That was clear from those phone calls. You can get that phone call: 'Are you going to harm yourself? How are you going?' But really, if there is not that element of compassion and empathy for that human being, it's going to be futile, isn't it?

Mr SARGENT: Yes. As police officers, I was and they are very well trained to identify someone who is taking the mick. As soon as an officer walks in with me and I say, 'This is where I served and what I did,' automatically they go, 'Great. Someone who knows what I am talking about.'

496 The Hon. S.L. GAME: I also think this idea of the panel is really good. Sorry if it's a bit ignorant, but I am just trying to understand. I can really relate to the fact that that internal system of dealing with it within the police force has issues of confidentiality. There are issues of stigma and embarrassment. They want it to be a private matter.

I certainly feel that it makes a lot of sense for that to be an externally sought process where they can reach out on their own terms, in their own way, in a private setting and I like the idea of that panel and a known panel of providers so they can do that. I guess I am just trying to understand that balance between how it would work in the sense that in certain circumstances the work environment should be aware of certain situations. It may not be every situation that they need to know about. Would that then be up to the provider to make that decision that they need to inform the workplace? How would that operate?

Mr SARGENT: That would be up to the clinician and that comes under our standard duty of care, under our professional ethics and practice guidelines. We are duty-bound to note and inform anyone if a person is likely to harm themselves, harm another or commit a crime, then it's mandatory reporting. If an officer said to me, 'I'm going to do this to myself,' then, of course, my first action is to contact SAPOL health and wellbeing and make sure that the relevant actions are put in place so there are welfare checks or they are dekitted, taken off the road and they have immediate accessibility to services—absolutely.

497 The Hon. S.L. GAME: That seems to make sense to me, so basically they could have the actual detail kept totally private but the actions that need to be taken are communicated with the workplace. I guess I just worry about that if they are suffering or in a compromised state that perhaps you don't want that exacerbated by normal duties, but you're saying as a clinician you could help make that decision and say, 'Look, we don't need to reveal what medication you're on or how you're feeling about this, but I do need to let them know that I feel that you need to be on lighter duties or not subject to this sort of exposure for your wellbeing and everybody else's.' So that balance can be found?

Mr SARGENT: It can be found. I think the problem at the moment is that, as many of my officers have said, they've gone through the system and then they get a barrage of phone calls from their team saying, 'Oh, we didn't know you were coming off this or this or this,' and the ability for confidentiality to be kept seems to go out the window. That's the last thing they want.

I have also had officers who have returned to work and their whole station is saying, literally, 'We didn't know you were having a breakdown. We didn't know you were having' with all due respect 'a spaz attack. We didn't know that you were mental.' The culture, the terminology, the empathy and the realisation that okay, while these people are police officers, they are human beings. If we expect a higher level of mental health care for the general public, we should expect no less level for our police officers who are protecting the general public.

498 The Hon. S.L. GAME: Definitely. Thank you.

499 The CHAIRPERSON: You have touched on something really important there and that's around culture. To go back to your opening statement, you referenced that there may be officers who perhaps through seeking private help are being prescribed antidepressants and then are not feeling comfortable or safe to go and disclose that in the workplace. How widespread do you think this issue is and do you have any recommendations as to how this cultural issue can be addressed so people do feel safe and comfortable in coming forward and acknowledging that they are prescribed antidepressants?

Mr SARGENT: I think, unfortunately, the word 'antidepressant' is a very negative term. We can thank the United States for that one. We don't give everyone and we don't have everyone prescribed antidepressants because they're depressed. Antidepressants also work on what we call 'mood stabilisation', they work on anxiety and they also help in relation to managing hypervigilance and fight and flight.

I think education to SAPOL, well, it should be from the commissioner down, about what we call psychotherapeutic medications and that removing the established social stigma or socially derived view and putting it in a real context is greatly needed because not only do we have the initial stigma from SAPOL to the member who is taking those medications if they find out, the member is self-stigmatising because they are taking them. So an education campaign to identify that antidepressants will improve and help the officer function will actually help improve and help the officer return to work, possibly in a quicker timeframe, rather than looking at it as a negative.

500 The CHAIRPERSON: So officers are not coming forward and disclosing at the moment because they are concerned about—you used the phrase 'punitive' in your opening statement more broadly as to why people aren't coming forward and seeking help. Is that why they are not disclosing, if they are on antidepressants, and what does that ultimately look like in practice?

Mr SARGENT: People being moved from their patrol positions and being put into the watch house, because someone believes, 'We can't let them have their accoutrements—their firearm, their baton, their spray,' is completely outrageous. There are people being moved from one position to another, coming into work and going 'Oh, you're now working here,' people feeling stigmatised in relation to being told, 'What's wrong with you, why do you need that stuff?', 'Can't you handle it?' or, quite commonly, 'Why don't you just come down the pub and have a drink with the rest of us after work?' It is endemic, the view of how medications are perceived within SAPOL.

501 The CHAIRPERSON: Is it just medication or is it seeking help and having mental health issues more broadly?

Mr SARGENT: Both. Seeking help and admitting that I am not feeling well, I am not feeling okay and I need some mental health help. A lot of time at the station level it is just pushed

aside, treated offhand. Inappropriate statements are made about mental health, which don't serve to make the member feel any better. What does any human do who feels like they are not being supported or listened to? They withdraw within, they withdraw socially, they change. The workplace notices they change, and then all the questions about why they are changing or why they are having so many sick days become a complete snowball effect.

502 The CHAIRPERSON: In your opening statement, you referenced—and apologies if I have misrepresented this—officers demanding the files of other officers to manage their case. What does that actually mean? Are you referring to the EAS/EAP files and it is a superior officer or their manager who is accessing their files?

Mr SARGENT: Yes. This person who eventually left on adjustment disorder worked in that area and one of the things that caused him to become quite disengaged was seeing senior officers who didn't work in this area coming in and demanding to see an officer's medical file so that they could make decisions on the officer and their fitness to work, etc., being told by some staff there, 'No, you can't do that,' to which they just decided that they weren't taking that and physically took the file and then told the person in the injury management section, 'I'm managing this file from now on,' which is a complete breach of privacy and medical-in-confidence. I know that at least one to two of the nurses who worked in that area resigned because of the practices that occurred there, because ethically they could not accept that these people with rank could come in and just demand to have this.

503 The CHAIRPERSON: Earlier in your opening statement you mentioned that some psychologists, psychiatrists or social workers aren't able to access files that they have requested and that the reason for that denial of access has come back as being because of a disciplinary access.

Mr SARGENT: Yes. Administrative issues which were described to me as disciplinary matters in the officer's medical file, to which I responded with, 'That's not appropriate.' Within the clinical medical and health fraternity it is accepted that if a patient signs an authorisation for release it goes from one clinician to the next; we release those records. That's how we are fully informed of the patient's history. As I said, I was denied that on those grounds, to which I said, 'Well, that shouldn't be the case, number one.' That officer also had to lodge a formal FOI to get access to his records because he was being denied them.

In terms of other officers I have had, I worked with another officer's psychiatrist and between the two of us worked out that there were things written in his file that he had never been diagnosed with but he was being treated by SAPOL as if he had those issues, bipolar being one and alcoholism being the second. And this chap hadn't drunk for, like, 10 years. He was sober. Records need to reflect the truth.

I will also add in that I reached out to the PMO to request the return to work requirements for a certain officer who had been taken off the road. The PMO would only speak to me on the phone and told me them on the phone. I asked if I could have them sent to me. As clinicians they had received an authorisation to release information. I attempted to get the list of return to work requirements—and I can't get the officer back to work if I'm not given what SAPOL wants—and it took three occasions, and on the third occasion, again, there was nothing.

I then wrote an email and directed that if I did not get this information within one hour I would be seeking a direct meeting with the commissioner. Within an hour I received an email back from a PMO: no SAPOL markings on the email, no signature block on the email, just a list of the requirements, which I thought was very unprofessional. If we are trying to get officers back to work, why are we, the clinicians, being stonewalled in doing this?

504 The CHAIRPERSON: To go back to the health file and the disciplinary action file being combined, was it your understanding that the health records were being accessed in conjunction with any contemplation of disciplinary proceedings or vice versa?

Mr SARGENT: No. I was advised only that within the officer's health file it couldn't be released to me because of privacy, that privacy being that there were administrative disciplinary matters in his medical file.

505 The CHAIRPERSON: But no justification as to why the two had been—

Mr SARGENT: No.

506 The CHAIRPERSON: Would it be ordinary practice or appropriate—and I'm not saying that this is what has happened in this instance—for health records to be a consideration in disciplinary proceedings?

Mr SARGENT: They would, but it would be a separate file. You would not put them in the same file. A disciplinary file and a medical file are two separate documents. You can reference both of them, but they shouldn't be together.

507 The CHAIRPERSON: Should be kept separately. Members, did you have any further questions? Thank you very much for your time. Before we conclude today's meeting, did you have anything else that you would like to inform the committee about?

Mr SARGENT: Only that I make myself available at any time for providing guidance and advice, either to the committee or to SAPOL, because the mental health and welfare of police officers is directly and intrinsically very close to me. I think that a major shift has to occur due to the number of police officers who are leaving the force each week. Some numbers have estimated five officers a week—not all for injury, not all for retirement but a majority of them for mental health. So, yes, I think a lot needs to change.

508 The CHAIRPERSON: You say they're leaving because of mental health. Do you know if they're notifying SAPOL when they leave, if there are any exit interviews if they are disclosing that they are leaving because of mental health, or are most officers, in your experience, who are leaving for mental health reasons, not disclosing that to their employer as they leave?

Mr SARGENT: Funnily enough, most of them are not disclosing it because they believe that when they go for another job—and this may be their view, or it may be a reality—but they believe that when they go for another job and SAPOL is sought for a reference, they're going to be negatively portrayed because of their mental health if they advise SAPOL that they have left due to mental health.

509 The CHAIRPERSON: Thank you very much for your time today. A copy of your transcript will be provided to you. If you do have any clerical corrections, please do indicate to Shannon.

Mr SARGENT: Thank you so much for your time.

510 The CHAIRPERSON: Thank you so much, we really do appreciate your time and your experience as well. Especially having that lived experience component I think has been really beneficial for us.

THE WITNESS WITHDREW