The Perspectives and Experiences of Paramedics Using Employer Funded Counselling

by

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Abstract

This study uses an interpretive descriptive methodology to interpret and describe the perspectives and experience of paramedics who have accessed employer funded counselling. The intention of this research is to develop an understanding of when and why paramedics access counselling services, the barriers and enablers to accessing this service and the extent to which it meets their needs.

A purposive sampling strategy was used to recruit a non-generalisable sample of New Zealand paramedics (including intensive care paramedics) that had used counselling. Ten paramedics participated in this study. Data collection occurred through in-depth, semi structured interviews that were undertaken by the researcher. The data was analysed using Braun and Clark's six-step thematic analysis. The thematic analysis brought forward four main themes which have been presented to represent the organic order of the counselling experience. These themes are: *precipitating stress factors, catalysts for action, barriers to access and being the client.*

This study revealed that it was challenging for paramedics to access counselling due to a perception that it could be perceived as a sign of weakness and significant psychological injury by those they work with. Despite this perception, the experience for using counselling was worthwhile and beneficial for many of the participants. Counselling can assist paramedics with managing stress from the workplace as well as stress from outside of the workplace. Several practical barriers to access had negative implications on the ability of some paramedics to utilise the counselling service that was available to them.

Paramedics in this study accessed counselling in a reactive manner and tended to use it as a last resort. The threshold for accessing counselling was particularly high and in many cases it was at a breaking point. This breaking point was often characterised by a significant deterioration to the mental health of the participants.

It would be beneficial for paramedics to use counselling in a more proactive and ongoing way. For this to happen, ambulance organisations need to work to break down existing barriers to access and normalise the proactive use of counselling within their

workforce. Accessing counselling and other psychological supports should be a routine part of safe paramedic practice. Improved use of counselling by paramedics involves accessing counselling before a crisis point and implementing counselling as a part of ongoing proactive wellness.

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Attestation of Authorship

"I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person (except where explicitly defined in the acknowledgements), nor material which to a substantial extent has been submitted for the award of any other degree or diploma of a university or other institution of higher learning."

Signed:

Date: 12 December, 2018

Acknowledgements

List of Conference Presentations

The role of counselling for trauma workers: Insights from New Zealand paramedics. Northern Trauma Network, 11th December, 2018, Auckland, NZ

Using interpretive description to research paramedic mental health and wellbeing. Paramedic Research Symposium, 5-6th July, 2018, Melbourne, Australia

Psychological support for the student paramedic. Student Paramedics Australasia Conference, 26-28th April, 2018, Wellington NZ

Helping the helpers: The role of psychological support in paramedic wellbeing. NZ Resuscitation Conference, 19-21st April, 2018, Wellington, NZ

The perspectives and experience of paramedics using counselling. Paramedics Australasia International Conference, 23-25th November, 2017, Melbourne, Australia*

The role of counselling in supporting New Zealand paramedics. St John Peer Support Symposium, 10th October, 2017

Early findings on the use of counselling by New Zealand Paramedics. Survive and Thrive: Paramedic Mental Health and Wellbeing Symposium, 23rd June, 2017, Melbourne, Australia

This presentation was shortlisted for 'the best of the best', top three presentations of the conference. This meant that I got to present as a key speaker to all delegates.

Chapter 1

Introduction

In this thesis the perspectives and experiences of New Zealand paramedics who have accessed employer provided counselling will be examined using an interpretive descriptive methodology (ID). In New Zealand and many other developed countries, counselling is one of the main forms of employer funded psychological support for emergency ambulance paramedics. The paramedic experience of accessing and engaging in counselling is not well documented and to date there has been limited research focusing specifically on the paramedic experience of using counselling.

1.1 Research question

What are the perspectives and experiences of paramedics who have used employer funded counselling in New Zealand?

1.2 Aims

This research aims to provide insight into the experience of using counselling. This insight cannot be extrapolated from usage data.

The main aims of this study are:

- To explore paramedic perspectives and attitudes about the role counselling plays in supporting their wellbeing and functionality

- To explore when and why paramedics access counselling

- To identify the enablers and barriers to paramedics accessing the counselling

- To identify how counselling can be better utilised by paramedics for maximum benefit and identify ways in which ambulance services can better design and promote the counselling services to paramedics

In documenting the perspectives and experiences of paramedics who have used counselling, it is hoped that their experience of using this service can be interpreted

and described to enable other paramedics to use it more effectively. The perspectives and experiences of the participants in this study will be used to help inform the way in which counselling services are offered to paramedics by better understanding their experience of using the service.

These aims are congruent with the ID methodology; where the aim is to develop knowledge that is relevant for the context of a clinical discipline (Hunt, 2009). This research is important because, as pointed out by Shakespeare-Finch (2007), "it is usually assumed that if the services are being accessed, then the organisation has fulfilled its responsibilities" (p. 364).

1.3 The experience of the researcher and interest in the topic

I am an intensive care paramedic with 10 years' of clinical experience in New Zealand. My current full-time role is lecturing university undergraduate paramedic students about their mental health and wellbeing and the clinical assessment and management of mental health presentations in the community. Being an operational paramedic as well as a lecturer places me in an advantageous position to use my clinical judgement to interpret findings to inform paramedic practice. This clinically informed interpretation is an imperative part of the ID methodology (Thorne, 2016).

Beyond my own experiences and anecdotal accounts from colleagues, it has been difficult to explain to paramedic students and operational paramedics what the experience of going to counselling is like and what they might expect to get out of it. I have experienced first-hand the psychological challenges of paramedic work and I have also experienced using counselling as a paramedic. For me the experience of using counselling was a mostly positive and beneficial one.

Early in my career as a paramedic I undertook a postgraduate paper on professional supervision (also called clinical supervision) for health professionals. In a class of nurses, physiotherapists and counsellors, I was the only health professional whose employer did not provide or fund professional supervision. To partake in the postgraduate study, I arranged my own professional supervision for six months. This experience was much more beneficial than I anticipated. It helped me to learn new ways to cope with challenges related to my job

and also helped to improve my ability and skills in coping with possible future challenges. At the time I felt that this experience of receiving proactive psychological support and supervision was not congruent with ambulance culture. It seemed that accessing psychological support as a paramedic was something that was viewed as a last resort. This experience left me curious as to how paramedics use the counselling service that is offered to them and whether it meets their need. This thesis is the start of a journey to improve the psychological services that are offered to paramedics.

1.4   The paramedic role

Paramedics typically work on ambulances, respond to emergency calls, stabilise and treat patients and then transport them to hospital (Regehr & Millar, 2007; Courtney, Francis & Paxton, 2012; Bledsoe, Porter & Cherry, 2016). Other contexts that paramedics work include rescue helicopters, as community care practitioners and in various roles within the hospital setting (Bledsoe, et al., 2016). As paramedics become more qualified and specialised, work opportunities in the private sector are becoming more common in locations such as mines, oil rigs and warzones (Joyce, Wainer, Piterman, Wyatt, & Archer, 2009).

In New Zealand, ambulances are crewed with four different qualification levels, namely:

- First Responder: Advance first aid trained. A common volunteer qualification.

- Emergency Medical Technician: Basic ambulance qualification. Completed 6-12-month vocational training to achieve National Diploma in Ambulance. Assists the paramedic as part of their clinical role.

- Paramedic: Bachelor of Health Science in Paramedicine required. This level of practice includes skills such as intravenous cannulation and the administration of a range of drugs

- Intensive Care Paramedic: Postgraduate study in advanced resuscitation required. Officers at this level are specialists in critical care and are able to provide advanced airway management and a number of invasive skills (St John, 2014; Auckland University of Technology, 2015).

With an ageing population and reductions in some community health services, ambulance services in many Western countries are facing increased strain as they try to meet an unrelenting rise in call volumes (Moll van Charante, Van Steenwijk-Opdam & Bindels, 2007; Lowthian et al., 2011). Worldwide there is a move to find innovative ways to meet an ongoing increase in service demands (Ball, 2005; Williams, Onsman, & Brown, 2009). The paramedic profession is undergoing an evolution, with the development of a number of new primary care roles such as the provision of extended care paramedics who can treat patients in their homes rather than having to transport them to the hospital (Tunnage, Swain & Waters, 2015).

Paramedics also deal with a large volume of trauma and distressing incidents as a regular part of their work and may see more trauma in one day than some people may be exposed to in their lifetime (Scully, 2011). In the final weeks prior to the submission of this thesis, the findings of Beyond Blue's (2018) National Mental Health and Wellbeing Study of Police and Emergency Services in Australia were released. This study surveyed 21,014 first responders which included Police, Fire, Ambulance and State Emergency Services and found that one in three employees experience high or very high psychological distress (Beyond Blue, 2018). This statistic is of concern considering that one in eight among all adults in Australia experience high or very high psychological distress (Australian Bureau of Statistics, 2015, as sited in Beyond Blue, 2018). This study is one of the largest of its kind in the world and has provided strong evidence to support a number of smaller studies which have suggested that paramedics face significant mental health challenges as a result of their job.

1.5 Emergency Ambulance work in New Zealand

Paramedics in New Zealand generally work for either St John Ambulance or Wellington Free Ambulance. St John Ambulance, covers 90% of the New Zealand population and Wellington Free Ambulance covers the remaining 10% (Dicker, Davey, Smith, & Beck, 2018). The provision of ambulance services in New Zealand and some parts of Australia is unique because in rural areas, ambulance services rely on a large volunteer workforce to supplement the paid paramedic workforce (O'Meara, & Duthie, 2018)

Ambulance service demand in New Zealand has increased over the last 20 years. Since 2001, the reduction of afterhours primary health care such as general practitioner services,

has seen an increase in emergency ambulance demand (Tunnage et al., 2015). There is has also been a significant increase in the numbers of patients reporting to emergency departments, with the vast majority of these patients being transported via emergency ambulance (Ministry of Health, 2014). In 2019, paramedics in New Zealand are expected to be formally accepted as a registered health profession for the first time. This is an important milestone in the recognition of paramedicine as a modern and qualified health profession (O'Meara, & Duthie, 2018).

1.6 Employee assistance for paramedics

In a wide variety of professions, employee assistance programs (EAP) have been developed and provided by organisations to their employees to support their mental health and wellbeing (McLeod, 2010). EAPs usually offer employees with optional funded counselling sessions as well as a range of other services such as stress management training, finance and budgeting services and conflict management (Frey, Paul & Blum, 2005). In Australia, 80% of the top 500 companies offer an EAP service to their employees (Allday, 2013).

Most ambulance services in Australasia provide counselling to their staff within an EAP. Ambulance EAPs were historically based on Mitchell's (1983) critical incident stress debriefing (CISD) model which has a strong focus on structured debriefing after critical incidents. Ambulance services in Australasia have now moved to a more empowering approach that allows employees to self-refer to counselling and other support services on their own terms (Bennett et al., 2005; Shakespeare-Finch & Scully, 2005; Regehr & Millar, 2007).

Formal paramedic peer support programs are a significant support mechanism offered by ambulance employers to their staff and are often imbedded within ambulance EAP programs (Donnelly, Bradford, Davis, Hedges & Klingel, 2015). Peer support programs provide especially trained paramedic staff that can proactively following up with paramedics after they have attended a traumatic incident as well as being available for staff to self-refer to engage with a peer support officer for confidential support (Gouweloos-Trines et al., 2017). Some peer support programs are not embedded in the EAP program and are offered alongside the EAP.

1.7 The provision of counselling by New Zealand ambulance services

In New Zealand, both St John Ambulance and Wellington Free Ambulance's EAPs offer counselling sessions to their staff from an external counselling provider (St John, n.d.-a; Stratos, n.d.). Both ambulance services allocate their staff three counselling sessions per year, which can be extended upon approval by their organisation (Stratos, n.d.; St John, 2018). (See Appendix A for copies of the EAP brochures for both St John Ambulance and Wellington Free Ambulance).

1.8 Research in paramedicine

Over the last 15 years, paramedic education in New Zealand, Australia and the United Kingdom has moved from a model of vocational training to the new pre-employment norm of requiring a university paramedicine degree to be a paramedic (Joyce et al., 2009). Because paramedicine is an emerging profession, there is an internationally recognised need to increase the abundance and quality out-of-hospital research (Siriwardena, Donohoe, Stephenson & Phillips, 2010; O'Meara, Maguire, Jennings & Simpson, 2015). Qualitative research is less abundant than quantitative research within the paramedicine field (Perry, Reynolds, & Clare, 2018). It has been commonly identified that emergency healthcare fields tend to focus more heavily on quantitative studies (Choo, et al., 2015). The undertaking of this study is an opportunity to contribute to qualitative knowledge in the paramedic research field. Because of the limited literature available, some of the studies that have been used in this study are more than 10 years old and may draw on findings from emergency services other than paramedicine.

1.9 Organisation of thesis

This chapter has provided a background to this study and has established the aims and objectives that underpin this study. This background includes my own motivations and personal experiences that have led to the formation of the research question. This chapter also provides an overview of the paramedic clinical context in New Zealand as well as the psychological support services that are available to them.

In chapter two, a wide range of literature is reviewed to explore and document what is known about paramedics using employer provided counselling and other psychological supports. This chapter highlights the causes and consequences of different stressors for the paramedic and examines literature on the effectiveness of workplace counselling in general as well as specifically for the paramedic.

Chapter three discusses the interpretive description methodology that underpins this study and provides justification for the suitability of this methodology to address the research question. The importance of ethics to the research design of this study are also outlined in this chapter.

In chapter five the findings of the study are presented as four main themes. These themes are presented in a descriptive manner by focusing using the words of the participants to support and validate each theme.

Chapter six provides an interpretive discussion of the findings and explores the significance of these findings by drawing on current literature. This chapter also discusses the strengths and limitations of the research along with recommendations for practice, policy, and future research.

Chapter 2

Literature Review

2.1 Introduction

This chapter explores and examines available and relevant literature to document what is known about paramedics using employer provided counselling and other psychological supports. In order to understand this subject, this chapter first seeks to understand paramedic occupational stress, the consequences of this stress and the informal and formal ways in which paramedics cope with stress. The history of counselling in the general workplace is also discussed in this chapter and the evidence underpinning its role in supporting employees in both paramedic and non-paramedic professions is examined.

2.2 The challenges of paramedic work

2.2.1 Paramedic occupational stress

Stress is defined by McEwen (2000) as, "a real or interpreted threat to the physiological or psychological integrity of an individual that results in a physiological and/or behavioural response" (p.173). It is necessary to point out that the concept of stress is not always negative. In some instances, a certain level of stress can maximise performance and health (Le Fevre, Matheny, & Kolt, 2003). For the purposes of this discussion, 'stress' refers to dysfunctional stress; where a person's physical and emotional ability to cope is tested and there are negative consequences (Quick, Quick, Nelson & Hurrell, 1997).

Working as an ambulance paramedic is inherently stressful and involves regularly attending potentially traumatic incidents (Drewitz-Chesney, 2012; Avraham, Goldblatt & Yafe, 2014). Traumatic incidents can be described as stressful incidents that overwhelm or threaten to overwhelm a person's usual methods of coping (Mitchell, 1983; Alexander & Klein, 2001). Ambulance work is a juxtaposition of periods of calm which unpredictably and quickly change to periods of intense stress. Bavafa and Jónasson (2018) reported short term operational impairment in paramedics who had attended a traumatic or critical incident during their shift and recommend further breaks for paramedics immediately after attending

a critical incident. Halpern, Gurevich, Schwartz and Brazeau (2009) suggest that a break of at least half an hour was required for a paramedic to de-stress and calm down after a particularly critical incident. It appears that the less time there is between critical incidents, the greater the risk of a psychopathological impact on the paramedic (Nirel, Goldwag, Feigenberg, Abadi, & Halpern, 2008). With modern ambulance services struggling to keep up with call demands, paramedic fatigue and inadequate rest is a serious concern (Courtney et al., 2012).

It is difficult to predict which incidents may affect a paramedic adversely as there are many different factors that influence the way they may respond to trauma such as personality types and the level emotional support that is available (Shakespeare-Finch, 2007). Incidents that appear to be predictably stressful for the paramedic include cot death, critically unwell children, suicides, mental health emergencies and those where a patient or bystander shows aggression towards the paramedic (Clohessy & Ehlers, 1999; Alexander & Klein, 2001; Reynolds & Wagner, 2007).

Regehr, Goldberg, Glancy and Knott (2002) and Donnelly et al. (2015) both make the important point that it is not necessarily large, sensational incidents that are traumatic for the paramedic. They found that in some instances, common place events such as attending the lonely death of an elderly patient could have a lasting impact on the paramedic. In these cases, it was often personal contextualisation which made the event particularly distressing. Interestingly, the unique stressors of paramedic work are also what attract many people to the role with the unpredictable and challenging nature of emergency work providing a work environment proving to be more stimulating than other industries (Hetherington, 2001).

Despite a strong focus in the literature on traumatic incident stress in paramedic work, organisational stressors such as paper work, poor resource allocation and poor management styles were frequently found to be the most significant cause of stress to the paramedic (Hetherington, 2001; Reynolds & Wagner, 2007; Scully, 2011; Gouweloos-Trines et al., 2017). Stinchcomb's (2004) study into police officer stress revealed a similar finding on the significance and implications of organisational stress. Paramedics also work long and dysfunctional hours, which is a major cause of stress at work and a cause of disruption to their personal lives. Paramedics report high levels of sleep deprivation and fatigue which

can negatively affect their physical mental health and can also affect clinical decision making and patient care (Van der Ploeg, Dorresteijn, & Kleber, 2003; Courtney et al., 2012). The findings of these studies emphasise the role and obligation of ambulance organisations in reducing chronic occupational stress in their staff (Bennett et al, 2005; Regehr & Millar, 2007).

2.2.2 Psychopathological consequences of occupational stress

Historically there has been limited evidence to conclusively validate the rates of mental disorders within paramedic populations because research on paramedic mental health and wellbeing is a niche and emerging subject area (Sterud, Ekeberg & Hem, 2006). The recent study by Beyond Blue (2018) into first responder mental health in Australia has provided a significant body of evidence which has validated previously published smaller studies that reported high rates of mental health problems in paramedics (Smith & Roberts, 2003; Courtney et al., 2012; Gayton & Lovell, 2012). The Beyond Blue (2018) study reports that 39% of ambulance staff had been diagnosed with a mental health condition in their lifetime compared with 20% of adults in Australia (Australian Bureau of Statistics, 2015). This new study appears to be the largest study into ambulance and first responder mental health ever undertaken in the world with 21,014 first responders taking part, of which 4378 were from the ambulance service.

Within the literature, the most agreed upon psychopathological concern affecting the health and wellbeing of the paramedic is post-traumatic stress disorder (PTSD). PTSD is an anxiety disorder which occurs after a traumatic event and can manifest as nightmares, flashbacks and/or a state of hyperarousal and hypervigilance which can continue long after the traumatic event or events have occurred (Drewitz-Chesney, 2012). Paramedics have some of the highest incidence of PTSD amongst all emergency services, with some studies predicting that up to 22% of paramedics will develop PTSD, compared with 1.3-3.5% of the general population (Clohessy & Ehlers, 1999; Bennett et al., 2005; Mcfarlane, Williamson, & Barton, 2009). Beyond Blue (2018) reported that 8% of ambulance workers had 'probable PTSD' compared with a rate of 4% in the adult Australian population (Australian Bureau of Statistics, 2015). A particularly important finding from this study was that "employees who had worked more than 10 years were almost twice as likely to experience psychological

distress and were six times more likely to experience symptoms of PTSD" (Beyond Blue, 2018, p.14).

Although the statistics about paramedic mental health are alarming, it is important to acknowledge that a significant proportion of the workforce is doing well in terms of mental health. Beyond Blue (2018) emphasises this point in their executive summary by saying "many employees and volunteers have good mental health and wellbeing with more than half of all employees and two in three volunteers reported high levels of resilience" (p.14). Berger et al. (2012) make the point that although PTSD rates in paramedics are higher than the general population, these rates could be considered low when you consider their high frequency of traumatic exposures that a paramedic has compared to the general population. It is important for researchers and organisations not important to not underestimate the ability of paramedics to cope with stress and trauma.

Burnout is thought to be a common presenting issue for the paramedic in the context of their high occupational stress (Vettor & Kisinski, 2000; Nirel et al, 2008). Burnout is a state of work-related exhaustion where a job becomes largely unenjoyable and difficult to cope with (Brink, Bäck-Petterson & Sernert, 2012). Burnout begins with emotional and physical exhaustion and progresses to a point where a clinicians depersonalise patients in order to cope and experience pervasive decreased personal accomplishment (Maslach, 1982). Burnout can have a negative impact on a paramedic's patient care which further perpetuates the decreased enjoyment and engagement in their job (Vettor & Kosinski, 2000).

2.3 Resilience

Resilience is a combination of internal qualities and external resources that can be drawn on to effectively deal with challenging situations and 'bounce back' from challenges (McMurray et al., 2008). It is thought that resilience can be developed by learning from traumatic exposures as well as engaging in formal training around wellbeing and stress management (Gayton & Lovell, 2012; Clompus & Albarran, 2016). Exposure to trauma does not necessarily have a negative impact on the paramedic and can lead to 'post traumatic growth' and an improved level of resilience (Ogińska-Bulik & Kobylarczyk, 2015). Post

traumatic occurs as a result of paramedics learning how to better cope with similar incidents and stressors in the future and in some cases making positive changes to their lives after a traumatic experience (Shakespeare-Finch, Smith, Gow, Embelton & Baird, 2003; Kang et al., 2018). It is suggested that regular engagement with psychological support services is a key part of developing resilience in paramedics (Beyond Blue, 2018).

2.3.1 Paramedic mental health stigma

Stigma that is experienced by paramedics around their own mental health has been identified as a barrier to help seeking behaviour (Fox et al., 2012; Donnelly et al., 2015). Defining stigma as a concept is challenging due to a wide variation of definitions within the literature. Link and Phenlan (2001) say that, "stigma exists when elements of labelling, stereotyping, separating, status loss, and discrimination co-occur in a power situation that allows these processes to unfold" (p. 382). This definition has been developed from the review of many sources, including the founding work on stigma by Goffman (1963), who described being stigmatised as being reduced "from a whole and usual person to a tainted, discounted one" (p. 3).

A meta-analysis by Haugen, McCrillis, Smid and Nijdam (2017) found that one in three emergency workers (ambulance, police and fire services) experienced stigma around their personal mental health. The most commonly reported concerns about mental health stigma among paramedics relates to negative stereotypes which are often linked to a fear and shame around being seen as weak if affected by mental illness (Halpern et al., 2009; Haugen et al., 2017). It is suggested that a possible barrier to paramedics seeking psychological support is a fear that help-seeking behaviours could be perceived as a sign of being ineffective in their job role (Reynolds & Wagner, 2007; Lazarsfeld-Jensen, Bridges, & Carver, 2014). Petrie et al. (2018) have found that stigma around mental health in paramedics can lead to low engagement in paramedic mental health research which leads to the underreporting of mental health symptoms within the empirical data available.

2.4 Informal coping strategies

During their career, paramedics will develop a range of informal coping strategies and behaviours to meet the challenges of their job and manage stress. These strategies are

developed through personal experiences as well as being learned through observing the actions of colleagues (Regehr, Goldberg, & Hughes, 2002). Avraham et al. (2014) label these coping strategies as 'compensatory acts' because they are used to help compensate for the stress and trauma to which a paramedic is exposed.

One of the most common, and arguably effective of these strategies, is talking amongst colleagues after emergency calls. This informal debriefing process is helpful in working through both the emotional and operational components of a case (Regehr et al., 2002; Avraham et al., 2014). Informal debriefing is thought to be helpful because there is a shared experience of the event and a similar level of clinical knowledge and understanding between colleagues. Supportive and helpful colleagues have been shown to significantly improve a paramedics ability to manage their work stress (Regehr et al., 2002; Lowery & Stokes, 2005). While having time to talk and debrief after a critical call is clearly beneficial for the paramedic but it is not always possible because in many cases the paramedic is required to attend the next waiting call without delay (Alexander and Klein, 2001; Halpern et al., 2009).

The informal debriefing between paramedic colleagues often includes black humour which functions as a short-term stress reducing mechanism (Alexander & Klein, 2001; Drewitz-Chesney, 2012). Black humour involves the making light of distressing incidents through laughing and joking. In their study involving staff working at a high security forensic psychiatric unit, Kuhlman (1988) suggested that black humour offered "a way of being sane in insane places" (p.1085). Humour provides a physiological stress release through laughter, helping to distance the paramedic from the emotional trauma of the scene. This also improves social cohesion which is an important component of paramedic resiliency (Rowe & Regehr, 2010). This type of humour is usually restricted to the work environment which is consistent to Goffman's (1959) notion of their being areas of acceptable behaviour. Such humour would be out of place with friends and family that are not paramedics.

Family and spousal support is also an important informal coping mechanism that is utilised by paramedics to deal with work stress. High levels of this type of support has been associated with a reduction of PTSD rates amongst paramedics and police officers (Regehr,

Hemsworth, & Hill, 2001; Chopko, Palmieri, & Adams, 2018). It is important for paramedics to have a range of other coping strategies to also use to cope with work stress because their family members and spouses are themselves at risk of experiencing vicarious traumatisation as a result of listening to the stories of their loved ones (Avraham et al., 2014; Alrutz, 2017). It is also important to note that family and spousal support is not available to all individuals due to their personal circumstances (Reynolds & Wagner, 2007).

When attending an emergency call, the paramedic may deliberately emotionally detach themselves from the patient and a situation to reduce the emotional impact of what is being seen (Regehr et al., 2002; Clompus & Albarran, 2016). Some paramedics report that they detach from the emotions of a situation by specifically focusing on the technical activities involved in a patient's care (Avraham et al., 2014). Despite being a commonly used strategy to cope with traumatic calls, detachment amongst paramedics has been found to be helpful in the short term but counterproductive in the management of stress in the long term (Ashead, 2010; Kirby, Shakespeare-Finch & Palk, 2011). Detachment can encourage cynicism and a dehumanisation of patients and lends to paramedic not dealing with emotions that they may have in response to an incident (Haque & Waytz, 2012). Where possible, it is suggested that the best way in which to informally manage difficult emotional responses is by accepting and acknowledging them and subsequently talking about them with a trusted person (Adshead, 2010).

2.5 Organisational support

2.5.1 Managerial support

When staff perceive the support from their management to be of a high level, there are lower reported stress levels and a notable improvement in job satisfaction and there is an expectation amongst ambulance staff that their managers will provide them with practical emotional support (Regehr & Millar, 2007; Petrie et al., 2018). Despite the positive benefits of good managerial support, a lack of support from ambulance managers is a common concern amongst the paramedic workforce. Paramedics commonly report that their managers were poor at identifying signs of stress in staff and subsequently failed to provide appropriate support when it was needed the most (Regehr et al., 2002; Regehr & Millar, 2007, Halpern et al., 2009).

It is important to acknowledge that managerial support is logistically challenging in the pre-hospital setting due to the autonomous nature of the paramedic role and geographically diverse context of their workplace. The ambulance manager must also manage their own emotional needs as they usually fulfil a dual role which includes attending high acuity emergency calls (Regehr et al., 2002).

2.6 Peer support programs

It is common for Australasian ambulance services to offer a peer support service to their staff (Ambulance Service of New South Wales, n.d.-b; Queensland Ambulance Service, 2018; St John, n.d.-b). There is some degree of evidence that suggests that peer support programs are effective at supporting paramedics with work stress by creating a more supportive work environment (Scully, 2011; Donnelly et al., 2015; Gouweloos-Trines et al., 2017). Shakespeare-Finch & Scully (2005) found that confidentiality issues were a barrier to paramedics utilising peer support in their review of an ambulance service's EAP. These concerns seemed to be related to historic incidents where peer-supporters may have breached confidentiality. Interestingly, Shakespeare-Finch and Scully (2005) found that the peer supporters themselves had higher levels of wellbeing and reported an improved ability to deal with stress because of the learning and development that they gained from the role. Further research is needed around the role and effectiveness of peer support for paramedics.

The provision of counselling to paramedics will be discussed in detail in the next part of this chapter which begins by discussing the origins and evolutions of general workplace counselling.

2.7 General workplace counselling

2.7.1 Rationale for general workplace counselling

When counselling is provided by an employer it is usually as part of an EAP which functions to help employees cope with work place issues as well as personal and family concerns that might interfere with a worker's health (Carroll & Walton, 2003). Over the last 20 years, there has been a significant growth in the provision of EAPs and counselling services for employees in a range of professions (Joseph, Walker, & Fuller-

Tyszkiewicz, 2018). The prevalence of workplace counselling is linked to the belief that the performance of an employee can be negatively impacted by high levels of stress, personal issues and mental health issues (Kirk & Brown, 2003; Joseph et al., 2018).

Mental health issues such as depression and anxiety have been documented as the leading causes of sickness absence in the workplace (Murray et al., 2012; Joyce et al., 2015). A number of studies have demonstrated that employee engagement in short-term workplace counselling can reduce anxiety and depression symptoms (Gardner, Rose, Mason, Tyler, & Cushway, 2005; Collins et al., 2012; Mellor-Clark, Twigg, Farrell, & Kinder, 2013). It has been noted by McLeod (2010), that a reduction of depressive symptoms in employees can have a particularly positive impact on work performance and engagement. Workplace counselling has been linked to the early identification of mental illness and the subsequent prompt engagement in psychological and pharmacological treatment which leads to early symptom recovery (Joyce et al., 2015).

A reduction in employee stress levels after workplace counselling has been reported in police officers who had used workplace counselling. Carlan and Nored's (2008) study involving 1,114 police officers in the USA found a correlation between police officers working in departments that offered employee counselling and having lower stress levels over the short term. Millar's (2002) study involving 45 police officers in Scotland reported a significant reduction in participant stress levels post therapy. The findings from the police force are particularly relevant to paramedics as both professions are exposed to high levels of trauma, work dysfunctional hours and both occupations appear to have stigma around the seeking psychological support (Brough, 2004).

In examining the longer-term benefits of counselling, Collins et al. (2012) found that employees of a University in the United Kingdom appeared more able to cope with the demands of their work and displayed improved wellbeing beyond six months after engaging in short-term counselling. A study examining the effect of counselling on 89 Norwegian doctors found a significant reduction in emotional exhaustion, mental distress and job stress in those who had engaged in a one-off, day long counselling session (with a psychiatrist or psychologist) when reviewed at one and three-year follow-ups (Isaacson et al., 2010). These findings are important as they suggest that counselling has the potential to improve a

person's coping ability and long-term wellbeing after their engagement in short-term therapy

The financial costs and benefits for organisations that invest in employee counselling are difficult to report on due to the majority of studies being based on the investment return of whole EAP programs. When reviewing studies into the cost benefit of EAP programs it appears that there is a positive dollar return on organisational investment in these programs (Hargrave, Hiatt, Alexander, & Shaffer, 2008; Joseph et al., 2018). A number of studies have reported on reduced rates of absenteeism when quantifying possible financial returns for organisations offering that employee assistance programs to their staff (Anema & Sligar, 2010; Joyce et al., 2015). Interestingly Joseph et al. (2018) suggest that presenteeism; where employees are attending their job with impaired mental functioning, is today more financially costly for organisations than absenteeism in terms of lost productivity.

2.7.2 Number of sessions required: 'Therapeutic dose'

Determining how many sessions might be required to achieve a therapeutic response from counselling is an important concept, but is one that is difficult to examine due to the different types of therapy approaches available and the large variance in the needs of clients (Hansen, Lambert & Forman, 2002). Agencies that provide their employees with counselling often limit the number of sessions that are available to save costs and also to ration services in order to make it available to a larger number of employees. These session limits in the most part have arisen without public consultation or reliable evidence to justify them (Harnett, O'Donovan, Lambert, 2010). Hansen et al. (2002) established from reviewing archival data sources that between 15 and 20 sessions of therapy were typically needed to observe a 50% rate of recovery among patients receiving treatment.

Collins et al (2012) explored the effectiveness of counselling for a university staff cohort who had access to unlimited employer counselling. The treatment group of 134 had a median of seven counselling sessions, with the range of sessions being between 1-19. In an Australian study of 125 adults from the general public who received unlimited psychotherapy sessions, it was found that it took 21 sessions for 85% of the participants to show reliable improvement (Harnett et al., 2010). When considering the session numbers

recommended by these studies, it appears that the three sessions offered by New Zealand ambulance services are below therapeutic levels

2.8 Counselling for the paramedic

The provision of counselling for ambulance paramedics has been based on a broad range of evidence that suggests that the personal impact of traumatic incidents can be reduced by providing a range of personal coping resources (Lazarus & Folkman, 1984; Van Der Kolk & Fisler, 1995; Bryant, Moulds, Gutherie & Nixon, 2003; Shakespeare-Finch, Smith & Obst, 2002). There is a need for further investigation into the effectiveness of counselling for paramedics due to limited empirical data in this area and also because their profession has an arguably greater need for the service than other occupations.

Shakespeare- Finch & Scully's (2005) 'Multi-method evaluation of an Australian Ambulance Service EAP' is the most significant study that investigates the use of counselling by paramedics. In their survey of 661 ambulance personnel, they found that the most common reason for accessing counselling was to attend to work issues that were not trauma related. The second most common reason was personal and family issues. This finding is consistent with the findings of Millar's (2002) qualitative study into police officers and counselling where police officers most commonly used counselling to help with non-traumatic stressors despite their high occupational exposure to traumatic incidents. Both of these studies reported a high level of satisfaction from the participants who used counselling.

Shakespeare- Finch & Scully (2005) and Regehr et al. (2002) suggest that information on notice boards and receiving a referral from management were the most common ways that paramedics were informed about counselling and EAP services. Regehr et al. (2002) reported that when paramedics sought professional psychological support to deal with traumatic events, it was often self-referred. This can be partly attributed to the fact that the events flagged by organisations as being critical or traumatic were not necessarily the events that the paramedic found distressing.

2.9 Summary

It is clear from the literature that working as a paramedic is a highly stressful occupation. Paramedics attend a high number of traumatic incidents which can have a negative impact on their mental health and work performance. Despite the consistent provision of peer support and counselling as part of Australasian ambulance service EAP's, there is scarce documented evidence on the benefit of these services for the paramedic. Counselling clearly can be beneficial and enjoyable for employees across of a range of organisations. To what extent these benefits occur for the paramedic are largely unclear.

Chapter 3

Methodology

3.1 Introduction

The primary motivator of undertaking this qualitative inquiry is to produce findings that can be applied to the paramedic profession with the goal of improving the design and utilisation of paramedic counselling support services. This desire to apply research findings to practice has led to the selection of Sally Thorne's un-categorised ID methodology (Thorne, Kirkham & MacDonald-Emes, 1997).

This chapter describes and justifies the selection of qualitative ID to underpin this study rather than choosing a more conventional qualitative methodology. The methods that have been used to gather and analyse data will be discussed in detail in this chapter as well as the ethical considerations that have been integrated throughout the research design.

3.2 Qualitative research

A qualitative paradigm was selected for this study as the research question seeks to explore and develop a deeper understanding of the lived experience of paramedics who had used counselling (Babbie, 2016). Qualitative research is a type of social research where the researcher seeks to make sense of human experiences by observing and interpreting the ways in which people interact with the societies in which they live and work (Babbie, 2016; Creswell & Porth, 2018). A quantitative approach has not been chosen for this research as it is more suited to studies that examine pre-defined variables and usually require a statistical analysis of numerical data (Patton, 2014).

In health research, a qualitative approach can provide rich insights into the interactions between those providing healthcare and those receiving health services (Morse, 2012). This study explores an interesting healthcare dynamic whereby the health provider (the paramedic) is themselves undertaking the role of the patient or client by engaging with professional counselling services. The sharing of human experiences can provide important

insights that can change the status quo which is an important objective of this research study (Morse, 1991).

3.3 Interpretive description (ID)

ID was developed by Thorne et al. (1997) to meet the needs of nursing scholars that noted a shortfall with traditional qualitative methodologies to answer research questions that were grounded in their clinical setting (Hunt, 2009; Thorne, 2016). ID provides a methodological vehicle for scholars in applied health areas to undertake qualitative research that utilises their clinical expertise to pragmatically interpret and apply findings to real-world clinical practice (Thorne, 2016). This application of findings has the intended outcome of changing clinical practice and to "yield legitimate knowledge for our practice" (Thorne et al., 1997, p.172).

Although ID was originally developed with the nursing profession in mind, over time it has proven to be a suitable methodology for other applied health professions such as paramedicine (Thorne, Kirkham, & O'Flynn-Magee, 2004). Nursing and paramedicine have the commonality of a clinical underpinning and share the need to be able apply their research finding to their practical professions (Ross, 2012; Thorne, 2016). In more recent years paramedicine and nursing have become more similar as more paramedics are being trained in nursing skills in order to meet the increasing primary care demands on ambulance services (Woollard, 2015).

Despite deviating from the rules of well-established methodologies such as phenomenology, ethnography and grounded theory, Thorne (2016) makes it clear that ID is not a completely distinctive approach and openly encourages the use of different methodological components to best address the research question. ID departs from these traditional methodological constructs to allow room for postmodern thinking through the utilisation of the researcher's rich knowledge and personal experience within the clinical contexts being examined (Dzurec, 1989; Thorne et al., 1997).

In an approach that is consistent with a constructivist and naturalistic epistemology, the researcher's point of view is used to construct clinically applicable meaning from the experiences of the participants. This epistemological underpinning acknowledges the

subjective and contextual nature of the individual human experience and allows for the possibility of shared realities (Lincoln & Guba, 1990; Frey, Botan, & Kreps, 1999; Thorne, 2016).

My personal first-hand experience of the emotional demands of paramedic work has informed and fuelled my curiosity about the ways in which paramedics manage their wellbeing and engage with counselling services. To undertake an ID enquiry, my practical experience is necessary to develop a practice informed research question and to deeply understand the natural work setting of the participants (Thorne et al., 1997; Hunt 2009). Thorne (2016) suggests that clinical experience is an essential requirement of being able to apply the findings of this study to change and improve practice. My understanding of the paramedic profession in both a clinical and organisational sense will help me to make relevant and applicable recommendations for changes to policy around the provision of counselling for paramedics in New Zealand.

When choosing ID as the methodology for this study, my position as a novice researcher and the fact this was for a master's thesis was considered. Smyth (2012) suggests that this methodology is particularly suited to a master's level study and cites as one of its primary strength is its 'straightforwardness'. Thorne et al. (2004) adds that ID is an effective methodology for smaller sample sizes as the researcher's experiential knowledge can generate meaningful and applicable findings from the data that is available.

3.4 The consideration of other methodologies

For this study, I initially considered using a qualitative descriptive methodology which would have produced a detailed description of the phenomenon and help to explain patterns of human behaviour, however, this approach lacked the opportunity for the clinical application of findings (Thorne, Reimer, Kirkham, & MacDonald-Emes, 1997). Thorne (2016) suggests that nursing research has little use for description by itself without the researcher's interpretation. Because of the practical nature of health care work, the interpretation of the researcher is critically important in providing purposeful direction for clinical application and improve practice (Crotty, 1998).

Grounded theory was also considered as a methodology for this study. Grounded theory creates theoretical ideas from social interactions and specifically focuses on theory being formulated from the data and not from other sources (Glaser & Strauss, 1967). Grounded theory did not meet the objectives of this study because the outcome of this study was not to develop theory but rather to capture and interpret meaning from the participant's experiences and practically apply the findings of the study.

3.5 Ethical considerations

Ethics approval for this study was granted by the Auckland University of Ethics Committee (AUTEC) on the 17th of June 2016, ethics approval number 16/224 . On the 6th of December 2016, an amendment to the ethics application was made to allow for a wider reaching recruitment of participants by using a professional paramedic body to disseminate the invitations to participate in this study (see appendix B for the evidence of formal approval of ethics and the subsequent amendment).

Sound ethical considerations have underpinned the entire research process, from the inception of the research question and research methodology to the collection and analysis of data and the dissemination of early findings through a number of conference presentations. In qualitative healthcare research, ethics are of upmost importance because this type of research can involve highly sensitive issues with vulnerable participants (Sanjari, Bahramnezhad, Fomani, Shoghi, & Cheraghi, 2014).

3.5.1 Principles of the Treaty of Waitangi

Because this study was undertaken in New Zealand, the principles of The Treaty of Waitangi have been carefully considered and incorporated in the ethical considerations. The treaty of Waitangi can provide a framework for culturally safe research by using the principles of *partnership, participation and protection* (Wilson & Neville, 2009).

An effective *partnership* between the researcher and the participants was needed in for the undertaking of this study. The participants needed to trust the researcher and feel safe in order to disclose information on a sensitive topic (Elmir, Schmied, Jackson, & Wilkes, 2011). Confidentiality was an important part of establishing trust in this partnership. The

consent form that the participants signed helped to reassure the participants that the researcher will act honourably by maintaining their confidentiality.

Participation is a principle that was honoured by providing a fair opportunity for paramedics to be involved in this study. This was done by widely distributing recruitment emails and then selecting participants on a first come, first served basis to ensure fairness in recruitment processes. The opportunity to participate in this study has been promoted as an opportunity for paramedics to be involved in research to contribute to their field and also better understand qualitative research.

The *protection* of the participants in this study was of upmost importance and was achieved by identifying and mitigating potential risks to the participants. Assuring and upholding confidentiality is important in protecting the participants who are particularly vulnerable because of the stigma related to paramedics using counselling. The availability of funded counselling for the participants and the researcher was put in place to help protect from any emotional trauma from the sharing or listening to of potentially distressing topics.

3.5.2   Informed consent

Participation in this study was entirely voluntary and interested potential participants voluntarily contacted the researcher by email. The participants were informed of the risks and benefits of being involved in the study which is an important element in the process of giving informed consent (Babbie, 2016). Interested participants were sent a participant information sheet (see appendix C for participant information sheet) by email and were given a recommended time-frame of two weeks to read the information and then confirm if they intended to be involved. The consent forms were then bought to the interviews by the participants and extra forms were available if they had been forgotten. The participants did not have to give written consent until the start of the interview which gave them a final opportunity to ask questions prior to giving consent. The participants could withdraw at any time up until data analysis had begun. These interviews happened over a six-week period, one month after the initial recruitment advertisement emails were sent out.

3.5.3 Confidentiality

The privacy of the participants in this study was protected in several ways in order to maintain confidentiality. Confidentiality occurs by the researcher protecting the privacy of the participants and ensuring that identifiable details about the participants are not made public. This study is not anonymous as the researcher can identify the participants as they undertook the interviews and the subsequent data analysis (Babbie, 2016). The electronically data that was collected from the participants will be securely stored for six years and then will be permanently deleted.

The participants were not identified at any stage to anybody other than the primary researcher who conducted all the interviews. Participants were allocated a participant number as their identifier in all transcripts and any subsequent formal and informal written material. Furthermore, all interviews were undertaken away from the work-place of each participant to avoid the participant being recognised. It was recommended to participants that their interviews took place in locations separate to their work-place and employer to ensure that confidentiality and privacy was upheld. Interviews in Auckland and Wellington were held at private interview rooms at either the Auckland University of Technology or Whitireia Polytechnic in Wellington. In a smaller New Zealand town, a meeting room at a community centre was used.

I took care to not report the details of ambulance incidents that I felt were identifiable due to the exceptional nature of the incident and the profile of the incident in news reports. My research supervisor provided guidance about these subjective decisions to ensure that confidentiality was being upheld.

3.5.4 Identification and minimisation of risk

It was anticipated that there may be some discomfort for the participants in identifying and talking about distressing work incidents that may have led them to access counselling. Such discomfort is a common risk in health research that involves interviewing participants about emotive subjects (Lowes & Gill, 2006; Sanjari et al., 2014). At the start of the interviews, all the participants were informed that the intention of the interview was to explore and understand their experiences of accessing and using counselling rather than the

details of any distressing incidents or personal circumstances that may have led to them use this service. However, because of the close relationship between distressing emergency incidents and accessing counselling (Shakespeare-Finch et al., 2010), it was not possible to completely avoid discussions about these incidents.

To assist participants with any discomfort, all participants were offered three free counselling sessions by an Auckland University of Technology (AUT) counsellor after the interview had taken place (see appendix D for letter of AUT counselling support for study participants). The participants were given the option of having these AUT counselling sessions via telephone, a consideration which was necessary to provide equitable access for those participants that were not based in Auckland. Lowes and Gill (2006) advises that some participants may find the experience of talking about emotive issues in the interview to be cathartic rather than distressing. I considered this point during the interview process and it reassured that me that it was okay for some participants to talk at length about a traumatic incident if they wanted to.

The availability of counselling support for the participants helped to protect me from being involved with the participant in a therapeutic capacity as it gave me the option of referring the participant for counselling if they experienced distress during the interview. To manage potential distress that I could experience from undertaking these interviews and being immersed in potentially distressing data, I sought monthly clinical supervision from a qualified counsellor during the data collection and analysis phases of the study, something which is recommended by Ryan, Coughlan and Cronin (2009) and Lowes and Gill (2006). In addition to clinical supervision I also had regular meetings with my academic supervisor. These opportunities helped me to not only maintain my emotional wellbeing but also helped me to maintain my objectivity and manage the personal biases that I had.

3.6   Recruitment

I contacted Paramedics Australasia (PA); a professional association representing paramedics in Australia and New Zealand, to request permission to advertise this study to their New Zealand members. PA gave their support and agreed to disseminate invitations to their New Zealand database by email (see appendix E for PA email advertisement). This advertising approach ensured that both Wellington Free Ambulance and St John Ambulance

paramedic staff were all afforded an equal opportunity to participate in the study without any influence from their employers. Members of Paramedics Australasia were also encouraged to share study information with non-members.

3.7   Participants

To be included in this study, participants needed to be a paramedic or intensive care paramedic, currently work for a New Zealand emergency ambulance service (in an on-road ambulance) and have previously used employee provided counselling. This inclusion criteria ensured that all participants had a similar work context and similar access to EAP counselling. Other paramedic roles such as remote paramedics on oil rigs were not eligible as their role involves different duties and stressors. Paramedics were only recruited from the North Island of New Zealand for convenience, and to avoid placing further stress on paramedics who had been involved in a number of significant earthquakes in Christchurch. Paramedics from Christchurch were thought to be unsuitable participants because this study examines the use of counselling in general rather than the result of significant disaster.

3.8   Sampling

The recruitment email that was sent to PA's New Zealand members reflected a purposive sampling strategy. This strategy is used in order to access participants that have the required knowledge and experience to address the research question. The use of purposive sampling is consistent with the ID methodology and is an effective approach to identify and seek out those who are better equipped than others to inform the researcher about the subject matter being explored (Patton, 2014; Babbie, 2016). Thorne (2016) calls these people "key informants" (p.99).

To increase the access to key informants, a snowball sampling approach to sampling was also employed. Snowball sampling is particularly useful when recruiting for a study that requires sensitive and personal information from hard to reach populations (Biernacki & Waldorf, 1981; Babbie, 2016). To utilise snowball sampling, the initial email invite to PANZ members encouraged recipients to consider inviting their colleagues to be involved in the study. The researcher hoped that barriers around mental health stigma could be overcome by paramedic peers promoting the study to each other. One instance where snowball

sampling was successful was where a participant contacted the researcher to be involved after seeing an advertisement for the study being shared on a paramedic's Facebook page.

3.9 Sample size

Initially the first eight recruited participants were interviewed. Once these interviews were complete, two further respondents were contacted and subsequently interviewed because the researcher felt that more insight could be gained to address the research question. Upon interviewing the tenth participant, I felt that I had gained sufficient insights into the perspectives and experiences of paramedics who had used counselling. With no new perspectives arising, I felt at this point that I had enough data to provide a deeper understanding of the research question and that could provide findings that could have transformative clinical application (Carnevale, 2002; Thorne, 2016).

The constraints of being a master's study was a consideration in limiting participant numbers; something that Thorne (2016) and Smyth (2012) suggests is an appropriate limiting factor when considering sample sizes for an ID study. Smaller sample sizes can render meaningful and impactful findings by utilising the researchers understanding of the research context and their ability to use their expertise to interpret the data (Thorne, 2016).

3.10 Data collection

The main data source for this study was the use of in-depth, semi structured interviews that were conducted face to face by the researcher in a one-to-one capacity with each participant. Individual, one-on-one interviews were used because they were covering emotionally intense subject material and this approach provided a safer space for the participants rather than a group interview. These interviews were conducted face to face to allow the social cues of the participants to be observed and to provide the researcher with a valuable learning opportunity to develop the skill of interviewing (Ryan et al., 2009).

I used an interview guide to provide a structure for each interview which lasted for no longer than one hour. This guide consisted of open-ended questions to elicit meaningful and detailed answers from participants and also to avoid guiding the responses to meet any preconceived ideas or prejudices of the researcher (Crotty, 1998). As this was my first-time

interviewing participants for research, I undertook two relatively informal practice interviews with paramedic lecturer colleagues and subsequently made changes based on their suggestions. The interview guide was altered during the process of data collection to ensure the best understanding was being gained to address the research question. There was extra time allocated during the interviews so unscripted questions could be asked. This flexibility allowed me to ask questions that could explore spontaneous topics that arose and enabled a deeper understanding of their experience (Ryan et al., 2009; Babbie, 2016).

All interviews were audio recorded and I took notes during the interview which were expanded on immediately after the interview to ensure that key features related to the interview were noted to help with my later interpretation of the findings (Richards & Morse, 2012). After the completion of all the interviews, I transcribed each interview verbatim; a process that further familiarised the researcher with the interviews and allowed further annotated notes to be made (Rowley, 2012). This process of note taking during the interview and transcription process is also part of the data analysis process. Thorne (2016) embraces this concurrent data collection and analysis as an essential part of the ID methodology.

3.11 Data analysis

"The initial phases of data analysis become a time of allowing ourselves to react to the initial pieces of data that are swimming around in the collective soup until they seem to rise to the surface and attract our attention" (Thorne, 2016, p.157)

Early data analysis occurred by taking down field notes during the interview process. During the six weeks that the interviews took place I continued to expand on these notes and write down new ideas in an unstructured way. This informal process of note taking continued during the process of interview transcription.

Once the interviews were transcribed, Braun and Clarke's (2006) six phases of thematic analysis guided me through the data analysis in a structured and sequential manner. Thorne (2004) supports the use of a structured approach for the novice researcher because it can help the researcher to avoid mistakes such as meticulously coding the data too early. Below I have outlined how I used Braun and Clarke's (2006) six phases of thematic analysis for this study.

Phase 1: Familiarisation with data. This first part of the data analysis involved becoming familiar with the data and considering 'what is going on' (Morse, 1994; Thorne 2000). In order to develop familiarity with the data, I undertook the task of transcribing each interview. This meant listening to parts of the audio a number of times and taking careful consideration to record the tone, meaning and intent of what the participants were saying. Further field notes were taken to record important ideas, themes and emerging patterns. The transcripts were then re-read and further notes were taken (Braun & Clarke, 2006). At this point my notes included a number of mind maps which helped my thoughts to evolve (Thorne, 2016).

Phase 2: Initial coding. The initial coding involved looking for important phrases, words and ideas which were then assigned a code. To assist with the initial coding, I formed three broad categories that related the sequential process of the counselling experience. These three categories were: 'before going', 'service access' and 'receiving counselling'. As the codes were identified, they were grouped into these three main categories.

Phase 3: Theorising. At this point, the identified codes were examined and several mind maps were used to help identify patterns and begin to construct broad themes and then consider the possible sub-themes (Braun & Clarke, 2006). In addition to the mind maps, colours were used to highlight possible emerging themes, an approach which helped to further immerse me in the data (Thorne, 2016).

Phase 4: Review of the themes. For this stage, the subthemes were more specifically refined under each main theme. This part of the analysis involved an ongoing review and adjustment of the themes to ensure that compelling and sensical story about the data (Braun & Clarke, 2006). Some similar themes were grouped together and renamed and others were dropped as there was not enough data to support them.

Phase 5: Defining and naming themes. Finally, the drafted themes and sub themes were further refined and then organised into the final themes and subthemes as shown below (Table 1). The definitive naming of the themes and subthemes provided an opportunity to review the overall structure of the thesis (Braun & Clarke, 2006).

Table 1

Organisation of Themes and Subthemes

Before going	Service access	Receiving counselling
Precipitating stress factors - Traumatic incidents - Personal life stress Catalysts for action - Mental health concerns - Encouragement	Barriers to access - Stigma - Booking processes - Geography	Being the client - Emotional relief - New tools and strategies - Getting the right counsellor

3.12 Rigour

The term rigor in research appears in reference to the discussion about reliability and validity (Lincoln & Guba, 1985; Davies & Dodd, 2002). As I am a novice researcher and intended on using the findings of the study to change practice, rigor is of upmost importance for this study.

3.12.1 Reliability

Reliability relates to the trustworthiness of the procedures that are used to generate the data (Stiles, 1993). From the inception of the study design through to the data collection and analysis, I consistently engaged with two colleagues who were qualitative researchers in healthcare to ensure I had agreement from expert sources (Graneheim & Lundman, 2004). An example of this was testing out my interview questions with these experts prior to undertaking my first participant interview. Recommended changes were made prior to undertaking the interviews.

Using Braun and Clarke's (2006) six step thematic analysis to guide my data analysis helped with the reliability of the study as provided a step by step approach for me to follow.

This step by step also made auditing the analysis process more straightforward and could be used as a reference point for my supervisor as they tracked my progress.

3.12.2 Validity

Validity relates to the accuracy of the research findings (Babbie, 2016). During the data analysis process, I had the valuable opportunity to present my preliminary research findings to my paramedic lecturer colleagues at a team meeting day and subsequently presented these preliminary findings at the Survive and Thrive, Paramedic Mental Health and Wellbeing Symposium in 2017. I then presented more definitive findings at a number of conferences in both New Zealand and Australia. These presentations provided the opportunity for me to field questions from 'external critics'. This engagement assisted me to further refine the themes by reconsidering their disciplinary relevance (Thorne, 2016).

In the second phase of the thematic analysis, my research supervisor performed an independent analysis of the transcribed data and then compared her findings with my findings. This enabled me to check the validity of the conclusions that I was drawing from the data set (Graneheim & Lundman, 2004; Bengtsson, 2015). From that point they continued to check findings that I was developing by referring to and analysing the original data set. My research supervisor is from a very different clinical setting which provided an alternative vantage point to my perspective which is grounded in my disciplinary experience. Our discussions helped illuminate the specific practice-based lens I was aiming to bring to the study.

3.13 Conclusion

This chapter outlined the rationale for choosing an ID methodology to answer the research question. As a novice researcher and experienced clinician, the ID methodology in combination with using a structured thematic analysis provided a study design which was simple to understand and effective in utilising clinical understanding to interpret data. As this study is a master's project and a learning experience, this chapter is an important part of the rigour of this study because "keeping detailed notes on decisions made throughout the process will add to the project's auditability and, therefore, reliability" (Roberts, Priest, & Traynor, 2006, p.43).

Chapter 4

Findings

4.1 Introduction

In this chapter, the findings of the research will be presented. The findings consist of four main themes that have been extrapolated from the analysis of participant interviews. These four themes are: *precipitating stress factors, catalysts for action, barriers to access and being the client*. The four main themes have been ordered in a way that best represents the organic process of the counselling experience. This structure has been employed to allow for a story to naturally unfold and to best convey the practical experience of accessing counselling (Birks et al, 2009; Thorne, 2008).

The purpose of this chapter is to present the more descriptive part of the research. Willcott (1994, p.287, as cited in Thorne, 2008) aptly articulates the intention of this chapter:

"When you emphasise description, you want your reader to see what you saw".

To preserve the power and meaning of what the participants have shared, an effort has been made to include quotes from the participants as much as possible when describing the themes. This chapter begins with a summary of participants and a table that provides an overview of each participant relating to their use of counselling.

4.2 Summary of participants

Ten paramedics (inclusive of intensive care paramedics) participated in this study. The majority of the participants were highly experienced, with only one participant having less than five years of experience. Six women and four men participated in the study. Several participants had received counselling within the six months prior to being interviewed and two were still actively engaged with a counsellor. Table 2 below provides a detailed overview of each participant and their counselling experience.

Table 2

Participant information

Participant	Gender	Method of getting information about counselling offered	Method of booking a counsellor	Counselling Session History (grouped into 1 year periods)
P1	Female	Asked a peer support officer	Phoned EAP provider	• 5 sessions • 5 sessions • 3 sessions
P2	Female	Asked a colleague	(attempted EAP website) Phoned EAP provider	• 8 sessions
P3	Male	Workplace website	External EAP website	• 3 sessions • 3 sessions
P4	Female	Asked ambulance service chaplain	External EAP website	• 1 session
P5	Female	Poster in ambulance station	External EAP website	• 1 session • 2 sessions
P6	Female	Poster in ambulance station	Phoned EAP provider	• 1 Session • 4 Sessions • 5 Sessions *(+ self-funded)*
P7	Male	Workplace pamphlets	Phoned EAP provider	• 1 session • 1 session • 3 sessions
P8	Male	Asked human resources advisor	Human Resources Advisor (on participants behalf)	• 6 sessions
P9	Male	Information from line manager	Phoned EAP provider	• 1 session
P10	Female	Manager advice and a referral to workplace nurse	Workplace nurse. (on participants behalf)	• 3 sessions • 8 sessions *(+ self-funded)*

4.3   Theme one: Precipitating stress factors

This theme explores the events and stressors that acutely or eventually overwhelmed the coping ability of the participants. For most of the participants, the decision to access counselling was reactive rather than proactive. Accessing the support of a counsellor was usually due to an inability to cope with stress from a participant's work-life and/or personal-life.

4.3.1   Traumatic incidents: "It's that one job that tips you over the edge"

For many participants, traumatic stress from paramedic work had a significant influence on their need for counselling. For several participants, it was an accumulation of traumatic work incidents that eventually overwhelmed their usual coping strategies.

I think that there is never a single incident that affects people, it's is the build-up of all the little ones along the way…you know…they just build up and build up… and then it's that one job that tips you over the edge.   P.9.

I find mental health patients quite challenging. Some patients I visit them more than once, in the same crisis over and over. When is this going to end? When they take their own life? Those are the things that trigger my PTSD to start cropping up again.   P.8.

It was difficult to separate whether it was that particular incident or it was the combination of a whole lot of other incidents.   P.7.

For some participants, their inability to cope and their need of support was attributed to one particularly traumatic incident. Some of these incidents were particularly distressing because a participant was able to identify with the patient or relate to the circumstances of the incident.

I have been to dozens of suicides and none of them affected me because there wasn't anything that related to me. I can think of one job that I was affected by, it was the cot death of a child that was the same age as my child at the time, and that deeply affected me.   P.3.

The experience of the participant below highlights that the emotional impact of a relatable incident is not necessarily linked to the incident's severity.

I remember being affected by a job where a lady had died home, and that was fine, but she had the same duvet cover as my parents. Nobody was going to be able to tell me that was going to happen but that was personal to me. Like wow this really hits home.   P.6.

Two of the participants accessed counselling in the months following the making of a clinical error while treating a patient because the making of a clinical error had a significant negative impact on them. These participants accessed counselling to help them with managing the guilt and loss of confidence that they experienced after these incidents.

It was probably the worst call I had attended in my 16 years in the ambulance service. The following shift I was getting ready for work and thought "shit I've done something wrong at that job and it is still playing on my mind". Then all week I had sleep issues and was trying to process the job. I started struggling with my confidence and I started to have issues with thinking "do I know what I'm doing?"   P.2.

Six hours later I went back to the address and the patient was in cardiac arrest, they were dead. I just felt horrific, like it was my fault. I still had to work the rest of the shift because I was the only ambulance available and I was working by myself… I went to counselling six months later because I realised that I still blamed myself for what happed at that job.   P.1.

4.3.2 Personal life stress: "Family stuff was affecting my job"

Stressors outside of the work place had a big impact on many of the participants and played a role in needing the support of a counsellor. It appeared that work and personal-life stressors often had a reciprocal impact on each other and in some cases they were difficult to separate.

I had massive family dramas going on and a relationship breakdown and I was also studying to be an ICP at that time and it was probably that I didn't do well in an assessment that kind of reinforced my thoughts that I am actually shit. All that pressure kind of just got to me and I would have nightmares about that job and dealing with that situation.   P.1.

Two participants accessed counselling for issues that were not directly work related and more related to their personal-life. In these cases, the participants found that the issues they were having in their home-life were having an impact on their work performance.

I sought counselling for issues outside of work. I am usually able to compartmentalise areas of my life and keep those personal factors separate to work, but from time to time, family issues do have an impact on my performance at work.   P.3.

The second time I went to counselling was personal, it was mostly around relationships. I learnt that it is extremely important to go about your personal life because ambulance work affects your personal life massively.   P.6.

One participant used counselling in a proactive way which contrasted the reactive use demonstrated by the other participants. This participant used counselling to talk through future life changes that would have a significant impact on their personal-life.

I went to counselling to try and get some good strategies for how I might approach a huge crossroads in my life. Do I move away from my partner for a few years in order to do a degree or should I just stick with life as it is?   P.5.

4.4   Theme two: Catalysts for action

This theme explores the catalysts which led participants to take action and book a counselling session.

4.4.1   Mental Health concerns: "It got to the breaking point"

For many participants, it was the stark realisation that their mental and physical health was suffering that led to accessing counselling. Some participants became concerned upon noticing problematic changes to their mood and interpersonal interactions. The realisation that their wellbeing was impacting the wellbeing of those around them was also a powerful catalyst.

The trigger for me was that I had a young family, I wasn't sleeping, I had lost my appetite and others started to notice that I was getting grumpy, getting shitty…short tempered, you know. Eventually I started to notice some of these triggers myself.   P.7.

For one participant, significant physical changes led to the realisation that they weren't coping.

I am always a neat and tidy person and well kept. I like the place to be clean and neat…but I'd stopped doing that. I'd get up late…I wouldn't bother doing my hair…I'd wear the same clothes as yesterday…the place was messy… and I just didn't care, which was really out of character. My diet got worse and I had let myself go weight wise which was also really unusual for me.   P.9.

Around the time of accessing counselling, one participant's health had deteriorated to the point of needing to take sick leave and see a doctor.

I realised I wasn't coping. I felt completely out of control and I was really nervy; so, I got on the phone and called the doctor. He put me off work and gave me sleeping pills and sedatives to take for the anxiety.   P.2.

A number of participants mentioned that sleep problems were having a negative impact on their mental health. For two participants, significant sleep disturbances were identified as a strong catalyst for deciding to book a counsellor.

I would have nightmares about that job and dealing with that situation. It got to the point that I was scared of sleeping at night because of the nightmares…so it was kind of towards that breaking point that I have to do something or I'll go crazy.   P.1.

I got to the point that I was not okay emotionally. The second red flag for me was that I wasn't sleeping properly and I was having nightmares…that kind of stuff.   P.8.

4.4.2 Encouragement: "I just needed someone to prompt me"

Many participants found that being encouraged by another person to use counselling had a positive influence on their decision to book a counselling session. One emphasised significance of others voicing their concerns about wellbeing to a paramedic.

If others come to you and ask if you're doing okay…like your colleagues, or your friends, or your family…if they highlight that they are worried about you , I think that you have got to the point where you should have already been going to counselling.   P.6.

For two participants, it was the comments from their spouse that pushed them to make their first booking.

After the incident the catalyst for getting help was my wife saying to me "what's going on? It's a becoming a problem. You're snapping at the kids and you're snapping at me". P.7.

My wife was giving me a bit of pressure to attend counselling even before the incident happened. I wasn't going to do it until I decided to do it. After the incident I finally conceded that my wife was right and I should go to counselling. P.9.

The decision for one participant to access counselling was made as a result of being approached by a manager about wellbeing concerns.

My line manager called me in and said – "are you OK? We have noticed that your approach to your colleagues isn't the same as it usually is. You seem to be getting a little bit short with people." So that was sort of the first red flag for me. I knew my behaviours and thinking hadn't been the same, I just needed someone to prompt me. P.8.

Two participants had unfavourable experiences with their manager. One participant felt that their manager was uninterested in their wellbeing and another participant felt that managers in general were not available to discuss such concerns.

Some managers don't have much time to talk about something stressful that might be going on. This one particular manager made me feel like he didn't want to know about that sort of shit. P.4.

The management structure means that we only have two supervisors on a shift. A lot of new staff don't even know what their territory manager looks like…how are you going to talk to someone that you don't know? P.1.

4.5 Theme three: Barriers to access

A fear of stigma and a lack of information and understanding around booking processes were common barriers that many of the participants faced when considering accessing counselling. In addition to these barriers, some participants from less populated areas had limited counsellor options.

4.5.1 Stigma: "Big boys don't cry"

It was agreed among the participants that there is stigma within the ambulance service around paramedics using counselling. Many participants said that it was rare for paramedics to discuss counselling experiences in the workplace and felt that it was unusual or exceptional for a paramedic to utilise the counselling service.

It's probably not that talked about, I certainly don't hear people openly talking about it. I know people who have really struggled in the past with certain jobs (cases) and a lot of burnout, but I have no idea if they have ever gone to counselling. P.1.

I think that there is a real negative stigma around seeking psychological help. The reason I feel this way is because I've had other officers who are senior to me say that they are on stress leave or have seen a psychologist...and then you think "oh that's really odd that you are telling me this as this isn't something that we discuss at all". P.6.

Many participants noted a culture of stoicism in their profession and felt that there was an expectation of them to have the ability to cope well under stress. In this context, some participants found it challenging to reflect on how they were coping and whether they might require additional psychological support.

In this job, because of the volume of work that you go to you don't get a lot of opportunity to stop and think if you might need support. You just go from job to job. For a long time, you wallow along and you sort of lift the lid, stuff it in and deal with it. And then you move on to the next job. P.7.

Still to this day it was the worst day that I have ever had. It was just horrible. I had a bit of a cry and told my wife about it and the next day I put my uniform on...you have got to be the paramedic that people look up to and respect. P.9.

There was concern among some participants that their using of counselling could be perceived as a sign of significant psychological injury or weakness.

"You've got to be a little bit crook, maybe a little bit nuts to need that" is the sort of impression I think that most of the staff have…There may be an assumption that maybe if

someone's not coping then they are not good at their job anymore or that they are struggling
with their profession.   P.3.

You can easily become the target of gossip in this organisation. For the more seasoned
paramedics there is the 'big boys don't cry' sort of thing to worry about.   P.7.

One participant suggested that stigma around counselling was related to the high
exposure that paramedics have to patients with severe mental illness.

Our exposure to mental health is quite negative because we often attend to people who are
having significant mental health issues and paramedics can forget that you can be a
functioning member of society and have anxiety or depression. When we think about mental
health, the first thing we think of is a serious crisis. Our exposure to mental health
perpetuates the stigma.   P.6

4.5.2   Booking processes: "But where do we get the details?"

Most participants attempted to independently make their first counselling booking by
either calling the EAP provider's phone number or visiting the provider's booking webpage.
Participants learned of these contact methods by various means (Table 1). A number of
participants found that they had limited access to information to guide them with the
process of booking a counselling session.

I would not say that the counselling service is easy to find. We hear "EAP EAP EAP", but
where do we get the details, who do we contact?   P.8.

I haven't seen it advertised anywhere at work. There are no posters on the wall or anything
that I have seen around...The time that I needed it I had to ask a peer supporter how to get
the phone number.   P.1.

The most straightforward booking experience was had by the three participants who
phoned the EAP provider to make a booking. These participants got their booking
information from a poster that was displayed in their workplace.

I saw a poster on the wall that said "do you need counselling?" "would you like to seek a service?"…and I was like "I think so". So from that point it was easy to arrange. I just called the phone number and they explained it all over the phone.   P.6.

In contrast to making a phone booking, the three participants who attempted to use the EAP website make their first counselling booking encountered the same problem of not knowing the required 'employer-specific' username and password. Two of these participants resorted to asking a colleague in order to get the details.

[name of employer organisation's] I.T. is pretty crap at the best of times. It is not easy to find the passwords that you need to book in a session and find out who the counsellors are. I ended up having to ask a colleague that I know well for the details.   P.4

Having to know the login and password…that's the first barrier. I rang a colleague at work because she is a really good friend of mine. I said "How do you use that site again?" She was able to help me by suggesting that I give the EAP phone number a try instead of using the website.   P.2

One participant who used the EAP website to book counselling for the second time in her career raised concerns about the potential for log-in issues to prevent distressed paramedics from accessing counselling.

Even when you find the link, it is password locked, so then you have to go and track down the password and the login info which, if for whatever reason you are not in a good space in your head it might be just enough to push you away from actually following through with it.   P.5

4.5.3   Geography: "The location of the counsellor is an issue"

For some participants, where they lived negatively impacted their access to employer provided counselling. Participants who were adversely affected by where they live generally lived in more rural areas where it was felt that there was less of a choice of counsellors and a higher likelihood of large travel distances compared with more populated cities.

It might be different in the bigger cities but once you get into the smaller communities there aren't many options around. There were limited choices because of the remoteness. At the end of the day it's who is able to facilitate the session.   P.7.

I think that the location of the counsellor is an issue. I live in an area where there might be three or four counsellors, and most of them, based on their profiles…are very very new to the profession. When choosing a counsellor, you are probably going to with one that is local… who is in your immediate radius of home, rather than go to someone that might be more specialised but is based further away.   P.4.

One participant was concerned about the likelihood of seeing a colleague or somebody they know when choosing their counsellor.

They asked me where I live and then gave me a choice of two places to go. One of the options was not very far from work, which was a little too close for comfort, so I opted for the other option which was further away.   P.2.

4.6   Theme four: Being the client

For most, the experience of attending counselling was a beneficial experience which enabled them to better cope with their presenting concerns. For two participants, the experience of counselling was unhelpful and unenjoyable. A number of participants felt that their counsellor could have been more specialised.

4.6.1   Emotional relief: "A weight had been lifted off my shoulders"

Apprehension and nervousness were commonly reported by the participants prior to their first counselling session. For many participants, this first session was unexpectedly enjoyable and provided them with an immediate emotional relief.

Before I went to counselling I thought it was going to be a bit of tree hugging hippies… "I don't need that"…but once I had been I realised I did need it. It was someone I didn't know at all so I could sort of dump everything on this guy. I got emotional in the session as I talked about a few of the jobs that that I had been to. I let him know everything in that hour and at the end of that I felt as though a weight had been lifted of my shoulders…and I just let that all go.   P.9.

For some, the experience of talking and being listened to by someone that was removed from their personal and work context was cathartic.

We could sort of debrief on a situation and my feelings and then defuse, or should I say decompress them. There was a lot of talking and listening from both sides which was good. I found it nice to sit and chat, and then be helped through the process of decompressing. P.8.

Several participants found the opportunity to discuss and examine their emotional responses to traumatic incidents to be of particular value. Some participants found it reassuring to hear that their emotional responses were normal, while others developed a better understanding around the severity of their emotional reactions.

I had been to a hanging a few weeks prior and noticed that I had become quite an angry person. I didn't have any feelings towards the patient and I thought that I should be upset, or I should be somewhat emotional. The counsellor helped me to acknowledge my emotions and see that my reactions were acceptable. She explained to me that you are allowed to not feel anything specifically emotional, especially in this emotional line of work...I was like "sweet! Okay, I understand why I am feeling this way." P.6.

It's actually been really good for me as I hadn't been able to process all the emotions of the job itself because at the time I was the most senior person at the job. When we explored the job it came as a shock as to how badly it had affected me. P.2

4.6.2 New tools and strategies: "She helped me to frame things in a more positive way"

Several participants learnt new tools and strategies in counselling, which in some cases, helped them to deal with future stressors. Three participants said that they learnt new psychological techniques that helped them to manage the negative thoughts that were causing them stress.

For me my mind is probably what is most damaging because I get stuck in these round about conversations with myself, telling you that you fucked up or you were shit or whatever. I learnt a thought stopping thing where it is basically self-talk, it's that simple, and you say it in your head so you don't look like an idiot and it just makes you stop the bad conversations that you are having and it kind of helps you to move on. P1.

We talked about the reasons why I was so stressed out and why the things I was doing to cope weren't working…instead of creating a negative connotation around not coping, she helped me to frame things in a more positive way that gave me more self-confidence and the self-belief that I actually can do this job.   P.10

One of the biggest skills that I learnt was to be a rugby player… do the same as they approach the scrum…pause, and then engage. Before acting I learned to go "hold on a minute, you are like a coiled spring at the moment…you need to pause…visit the emotion and say what is causing you to feel this way."   P.8.

In contrast to the positive learning experience of some participants, one participant found no therapeutic value in a particular learning technique offered by their counsellor.

I went to some art therapy 'hippie' lady who gave me a box of crayons and told me to draw my fears, literally. And because I wanted to talk about a traumatic job, I found this approach really inappropriate.   P.5.

4.6.3 Getting the right counsellor: "I would prefer someone that has a background with the emergency services"

The relationship between the participants and their counsellor was critical in determining the benefit of the counselling experience. Between the participants, there was a wide range of experiences and opinions of the counsellors that were used. Some participants linked the benefit of their experience to their counsellor's previous experience of working with ambulance staff.

It was helpful that he had a good understanding of paramedics and what we do. He'd been doing it for years and had seen a number of people that [ambulance employer] *sent in. In fact, he approached* [ambulance employer] *a number of times to say "hey your paramedics are broken and we need to fix this".*   P.9.

I chose her because I was told by someone else that she was particularly good at formulating plans, especially for work. She happened to see lots of ambulance staff…so she had a very good outline of the ways that the company runs already so I didn't have to divulge a lot about what we do as she already has an idea.   P.10.

Several participants felt that their experience of counselling could have been better if their counsellor was more experienced with counselling ambulance staff.

I found that I was a bit unsure that they really understand what I am telling them about how I feel about going to a certain situation…I would prefer someone that has a background with the emergency services, be it police, army, it doesn't matter. Somebody that has that background knows what it is like to be exposed to trauma and see people in their worst moment. P.8.

Most participants found their counsellor to be of some value, however, two of participants reported a highly dissatisfactory counselling experience. Both of these participants said that this experience put them off using the service again.

I just felt like she had absolutely no idea of the kind of stress that we have in our job. She was just not interested at all about knowing anything about what was actually happening and just her strategies for dealing with anything…I probably wouldn't go back to counselling, I'm a bit sceptical really.   P.4.

Her office was very crowded and messy. It didn't have good lighting so the physical environment was quite seedy as well. After this I felt really anti the whole profession for a while.   P.5.

4.6.4 The challenge of accessing multiple sessions: "I probably needed more"

Beyond an initial three sessions per year, many participants were unsure about their entitlement to receive further funded sessions. There was a significant variation in the understanding by the participants around what the processes and rules were around 'extra' counselling sessions.

As far as I have been made aware, each year you will get three funded sessions and then your counsellor is able to ask for an extra two funded sessions.   P.6.

It is a bit limiting that you are only allowed three sessions…well actually you are allowed a maximum of three sessions for any one problem."   P.4.

For two participants, session restrictions were cited as a barrier to their continuation of the therapeutic progress that was underway. Both participants found the personal cost of continuing with the therapeutic relationship to be prohibitive and unaffordable.

I ended up doing five sessions. After that the therapist wanted me to keep going with counselling but if I kept going to her it would have cost me 200 dollars an hour. I probably needed more at the time but I couldn't, not for free.   P1.

After I saw the counsellor for those five sessions I then had to wait for the financial year to roll over to be able to continue. So I waited and then reapplied as soon as the new financial year started. Realistically, personal costs do come into it if you want to be able to continue with the relationship.   P.6

Some participants reported a more favourable experience and had their sessions extended, in some cases, a number of times. These additional funded sessions were requested by their counsellor and subsequently approved by their employer.

After I reached the limit of three sessions the counsellor suggested that I have more and they got further sessions authorised by [ambulance employer]. *At the end of the sixth session they said "you are okay to move on independently". I think that those extra sessions gave me the time needed to talk through a few jobs and learn some new tools.   P.8.*

Normally in the program they give you three sessions. For me that has been extended to six, and then it was extended again, and now I am on the third extension. I haven't had to do anything, the therapist took care of all of that.   P.2.

4.7 Conclusion

In this chapter, the findings of this study have been organised into four main themes, namely *precipitating stress factors, catalysts for action, barriers to access and being the client.* To validate these findings, the themes have been presented using a number of extracts from participant interviews. The participants in this study appeared to have a high stress threshold for requiring counselling and most participants identified a number of barriers that delayed or prohibited their accessing to the service. For the majority of participants, engaging in counselling therapy was a positive and worthwhile experience.

Chapter 5

Discussion

This chapter provides the more interpretive aspect of this study and draws upon on relevant literature and my own clinical experience to discuss the significance of the findings and how they can be applied to inform paramedic practice. In the words of Thorne (2016), this chapter will discuss "what truly has been found… within the context of what is known" (p.215).

This chapter is ordered around the four themes that have been presented in the findings. The discussion in this chapter focuses on providing practical recommendations for paramedics on using counselling and for ambulance organisations on policy regarding the provision of counselling services for their staff. This chapter will conclude with the strengths and recommendations of the study and recommendations for future research.

5.1 Precipitating stress factors

This theme explores the precipitating stress factors that contributed to the participants in this study eventually requiring counselling. Two key sub-themes were identified; *traumatic incidents* and *personal-life stress.* In most cases where paramedics required psychological support in the form of counselling, the reason was multifactorial and there was usually a complex interplay between *traumatic incidents* and *personal-life stress*.

There appeared to be a difference between the perception of participants about what the counselling service would likely be used for and what it was actually used it for. Some participants in the study thought that they would use counselling for one particularly traumatic incident, however, in most cases, the participants accessed counselling because of accumulative and multifactorial stress factors. This is congruent with the research of Shakespeare-Finch and Scully (2005) and Carlan and Norde (2008) who noted that paramedics and police officers were more likely to access counselling for a combination of both work stress and personal issues. To change the perspectives of paramedics about what counselling can be used for, organisations need to promote the use of counselling as a normal part of practice and maintaining wellbeing. Because paramedics get the majority of

their support and advice from their peers (Avraham et al., 2014; Alexander & Klein, 2001), it would be helpful to promote the experiences of paramedic role models or champions who have successfully engaged with counselling.

For two experienced participants, the making of a clinical error had a severe impact on their mental health and clinical confidence which lead them to accessing counselling. The relationship between clinician error and a deterioration of mental health has not been well studied within paramedicine, however, there is substantial evidence of the impact of clinical errors on medical doctors (White et al., 2015; Van Gerven et al., 2016). A number of staff support guidelines for hospital physicians suggest that staff who have made an error should be referred to an external agency for ongoing psychological support for the duration of an investigation (White et al., 2015; Pratt, Kenney, Scott, Wu, 2015; Scott & McCoig, 2016). With the prospect of registration occurring soon for New Zealand paramedics, this type of support is something that could be included in training and workplace policy.

Concerningly, one of the participants in this study, who made an error, exhausted their allocation of free employer provided counselling after five sessions, prematurely ending their therapeutic progress. Paramedics require further education to highlight the relationship between making a clinical error and their mental health. Furthermore, paramedic managers need to ensure that counselling and other forms of employee assistance are strongly recommended to participants in instances where a possible clinical error has occurred. Clarification around the availability of more than three sessions is especially needed when staff are referred to counselling after making an error. This is because the guilt and loss of confidence that occurs can be ongoing.

Personal-life stress was reported by some of the participants in this study as a significant precipitating stress factor which is congruent with the findings of Shakespeare-Finch and Scully (2005). Two of the participants identified that their personal-life stress was affecting their ability to do their job. This is important considering the clinical responsibility that the paramedic has when undertaking their job. Counselling should be clearly promoted to paramedics as a service for assisting with issues occurring outside of the workplace in addition to dealing with the obvious trauma associated with their work. This is an area where paramedic champions could be utilised to promote the role of counselling.

5.2 Catalysts for action

This theme was formulated to make a clear distinction between precipitating stress factors and a participant's eventual realisation that counselling was needed; 'the catalyst'. In most cases there was a delay between the exposure of a participant to a stressful event or events and the realisation of their need of counselling. The two sub-themes *mental and physical health concerns* and *encouragement* were two important catalysts that emerged.

A concerning finding in this study was that a number of participants decided to access counselling when their mental health had deteriorated to a 'breaking point'. Millar (2002) found a similar theme in her study of police officers using counselling. Millar titled this theme: 'at the end of my tether'. Because paramedics tend to use counselling as a last resort, ambulance organisations need to work to promote the proactive use psychological support services such as counselling. One approach could be to frame and structure employee provided counselling as 'clinical supervision' in order to make counselling a more routine part of practice. Clinical supervision has been effectively used by a number of health professionals such as nurses and counsellors to provide them with support around clinical issues and to develop self-care (White & Winstanley, 2010; Bernard & Goodyear, 2014).

In some cases, sleep disturbances and nightmares were a contributing factor to the 'breaking point'. There is clear evidence that sleep deprivation has a negative impact on mental health and a person's resilience to stress (Tsuno, Besset, & Ritchie, 2005), and has a positive correlation to the occurrence of PTSD (Belleville, 2009). It is important for paramedics to be educated on how to manage their sleep and they need to be encouraged to seek help proactively with their general practitioner (G.P) for sleep issues. Ongoing clinical supervision or proactive counselling would help paramedics to be more reflective and aware of their sleep patterns.

Some of the paramedics in this study found that receiving encouragement from a concerned domestic partner to attend counselling to be an important catalyst in using the service. It appears that partners are able to pick on behavioural changes in the paramedic that they may not have recognised themselves. This ability of a partner to get a paramedic to seek psychological support could be enhanced by more formally involving these partners in the ambulance organisations. St John Ambulance Western Australia (2018) provide family

members of their ambulance staff six counselling sessions each per year. This is an exemplary offer of support which helps to address the recent findings from Alrutz (2017) in New Zealand that one in five partners of emergency first responders were at risk of PTSD and around half of partners that participated in the study felt under informed by ambulance organisations.

An ambulance manager also has the potential to positively influence a paramedic's help seeking behaviours through encouragement. In this study three participants found encouragement from their managers to be helpful, and two participants found their managers unhelpful and unsympathetic. Some participants found it helpful to have been told to access counselling instead of having to decide when it was a good time to ask for help. It has been recommended in literature that in order to improve the mental health and wellbeing of paramedics, ambulance managers require further training in mental health literacy and in particular the identification and support of staff with mental health concerns (Petrie et al., 2018). Furthermore, if managers could lead by example and share their experiences, more staff might feel comfortable to access counselling.

5.3 Barriers to access

Once the participants had realised that they had a need to access counselling, a number of barriers to accessing the service became apparent. These barriers to access were problematic because the participants tended to try and access counselling when they were at a 'breaking point'. In this state of significant stress, small barriers had big implications. *Stigma, booking processes* and *geography* made up the three subthemes of this section.

In this study there appeared to be a conspiracy of silence where paramedics did not discuss or disclose their use of counselling. In many cases this was because of a fear that they would be seen as mentally unwell or not fit for work. Stigma around paramedic mental health is well documented (Halpern et al., 2009; Chapman et al., 2012; Fox et al., 2012, & Haugen et al., 2017). Interestingly, many participants in this study perpetuated this stigma by seeking counselling when they were mentally unwell and unable to perform at work. To break this silence and cycle of stigma, paramedics need to feel able to share their experiences of using counselling because the sharing of personal stories is a powerful way to break stigma (Corrigan, Kosyluk, Rusch, 2013). It would be beneficial if paramedics shared

stories of the proactive counselling use. It would be helpful for ambulance organisations to promote the stories of role model staff members who are willing to share their experiences of using counselling.

It is hoped that the powerful stories from the participants in this study will have some influence in reducing this stigma around paramedic mental health and counselling. The opportunity to undertake a number of conference talks about the findings of this study to an international audience has been a valuable way to help to normalise the use of counselling and get people talking. After doing these talks, I have had countless conversations with paramedics who have voiced appreciation for me talking about a topic that we need to be discussing more. These conferences talks have had a wider reach, with a large number of photos and quotes from my talks being shared by paramedics to their peers around the world on Twitter. One New Zealand paramedic publicly posted about their use of counselling on twitter, "I just picked up the phone & made an appointment. It's been over 12yrs since my last. Thanks for the prompt @aripeach_NZ, so very valuable!" (Mullooly, 2017). It is encouraging that a talk I gave on the findings of this study prompted this paramedic to go to counselling and that they were comfortable to share this publicly.

Booking processes were a significant barrier to accessing counselling. A number of participants in this study who tried to book counselling online were unable to so immediately because they did not have the log-in name and password that was required. This barrier became more problematic due to a fear of sigma if they were to ask a colleague or manager for these details. The login and password barrier is a reminder that support service systems must be robustly user tested. To ensure this, it is suggested that paramedic managers regularly use the counselling services themselves so they can personally understand the experience and help to mitigate any barriers to access. Further research into managers and their experiences of counselling would be useful.

A final barrier to access related to living in a rural area. The paramedics in this study who were from rural areas had to travel further than their urban counterparts to get to counselling. In rural areas the participants felt that there were less specialised counselling services available, a smaller number of counsellors to choose from and a higher likelihood of personally knowing a counsellor. There is existing evidence within general rural populations

that show a reduced availability of mental health services and higher rates of mental health stigma (Happell, et al., 2016; Hoeft, Fortney, Patel & Unützer, 2017). These rural challenges in combination with paramedic industry stigma suggest that rural paramedics needs specific consideration when offering counselling and other psychological supports. It is recommended that the viability of offering telephone counselling services is investigated as an alternative option for all staff. There is evidence that telephone counselling has similar effectiveness to face to face counselling (Reese, Conoley & Brossart, 2002; Stead, Hartman-Boyce, Perera & Lancaster, 2013). Telephone counselling also would be a helpful option for metropolitan staff who have limited time available due to commitments such as childcare.

5.4 Being the client

This theme is particularly important because there appears to be limited literature available on the experience of the paramedic undertaking counselling and 'being the client'. The experience of being the client in counselling was broken down into four sub-themes: *emotional relief, new tools and strategies, getting the right counsellor* and *the challenge of getting more sessions.*

Many of the participants in this study found using counselling to be a favourable and therapeutic experience. This is congruent with Shakespeare-Finch and Scully's (2005) evaluation of an ambulance service EAP and Millar's (2002) qualitative study into the experiences of police officer using counselling. The paramedics in this study found it particularly helpful and therapeutic to discuss their emotional responses to work incidents and get an opportunity to ask: "am I a normal person?" (P.5). Paramedics could benefit from having regular opportunities to regularly access counselling to discuss their emotional responses to a range of incidents that they encounter rather than wait for an incident that overwhelms their coping ability.

A number of participants learned new tools and strategies about stress management which helped prepare them to face future stressors both in and out of the workplace. This is also congruent with Millar's (2002) research, in which she calls this "learning through participation" (p.163). This highlights the proactive benefits of counselling which could help a paramedic to prepare for future stressors and not just restore and recover after traumatic events. It would be advantageous for ambulance organisations to promote counselling as a

service for their staff as a proactive way to learn new tools. This would be of particular benefit to undergraduate paramedic students and new paramedic recruits. It would be of value to undertake a future study to measure the effect that proactive counselling has on the long term resiliency of new paramedic recruits.

Getting the right counsellor was an important factor in determining whether the participants in this study would engage in subsequent counselling sessions. To reduce the impact of a possible unfavourable first experience, paramedics need to be well informed about the qualifications and experiences of the counsellors that are available. Some participants suggested that it would be beneficial to be able to meet the available counsellors when starting employment with an ambulance service. This seems to be a reasonable way to practically improve the ability of the paramedic to choose the right counsellor for them and also normalises counselling at the start of a paramedics career. In this study, most paramedics preferred to go to a counsellor who had experience with counselling emergency workers. It has been reported in literature that a lack of training for counsellors around organisation specific systems makes the therapeutic process more challenging for the counsellor (Kirk & Brown, 2003). In order to improve the experience of counselling for both the paramedic and the counsellor, it would be helpful for counsellors to do a number of ride along shifts each year to better understand the paramedic role. Another approach, which has recently been implemented by Queensland Ambulance Service (2018), would be to employ 'in house' counsellors so ensure that they are well accustomed to the way organisations operate and become expert in counselling paramedics.

An initial allocation of three counselling sessions per paramedic per year appeared to be prohibitive of the proactive and ongoing use of counselling by the participants. A number of participants felt that the therapeutic relationship with their counsellor was ended prematurely. In non-paramedic literature, it is suggested that 10-15 counselling sessions were usually needed for a client to make measurable therapeutic progress (Hansen et.al, 2002; Harnett et al., 2010). Considering that paramedics are exposed to more trauma and stress than the general population (Drewitz-Chesney, 2012; Avraham et al., 2014), three sessions per year is likely to be insufficient. The findings of this study challenge the purpose and need for an initial three session allocation. While these yearly allocations remain, it is

hoped that it could be made explicitly clear to paramedics by their employers that these three sessions are a starting point only and further sessions would be funded.

5.5 Recommendations for policy and practice

This section provides tentative recommendations for paramedic practice and policy for both paramedics and the ambulance organisations that they work for.

- Newly employed paramedics should have an opportunity to meet with some of the counsellors available to them in their induction and have an opportunity to ask questions about the service.

- Mandatory counselling in the first year of employment would give new paramedics a chance to try the service in a proactive manner. This could be framed an 'introductory session' or as a session for 'planning ahead'. Specific objectives could be achieved in this session such as creating a self-care plan for managing stress in the long term.

- Further education for paramedics around the impact of clinical error on their mental health and the importance of engaging in psychological support services such as counselling.

- In house counsellors should be considered or alternatively ambulance organisations could provide a smaller more qualified pool of external EAP counsellors so that all counsellors are familiar with paramedic clients

- Rural paramedics should have the opportunity of telephone or video counselling. This could be extended to all paramedics if feasible.

- All managers should have used the counselling service that is available to them and the staff that they manage. This should be mandatory for managers so they can recommend these services with a reference point of their own lived experience. This will also help to user-test the service.

- The allocation of three sessions per staff member per year should be removed. If allocations are strictly necessary from an organisational perspective, this should be increased to ten sessions which can be extended.

5.6 Study strengths

The applied clinical nature of this research has helped to inform and develop my lecturing work on paramedic mental health and wellbeing. My role as a lecturer has provided valuable opportunities for mentorship and critique from experienced paramedic academics throughout the research process. This was particularly valuable when establishing the research question and subsequent research design. An effort was made to invite paramedics from both smaller provincial towns in New Zealand as well as larger cities to enable possible geographic variation. The opportunity to present at a number of Australasian conferences prior to the completing this thesis provided an opportunity for ongoing critique and new ideas which helped to improve the validity and relevance of this study as well as exposing a large number of paramedics to the findings and hopefully positively impacting on their perceptions of accessing counselling.

To improve the trustworthiness of this study, many collaborative sessions were held with my supervisor throughout the research process to bring forth and challenge emerging biases and preconceptions. The ongoing engagement with my supervisor; who is from another clinical profession, provided an alternative clinical perspective and helped to ensure that the findings were applicable to other health professions beyond paramedicine.

A particular strength of this study is the impact that is has had on making changes to paramedic practice. An example of this is that I have had a number of meetings with St John Ambulance in New Zealand about improving the online access to counselling. As a result of this research and these meetings, St John Ambulance has changed the main banner on the home page of their staff internet site to provide a direct link to mental health and wellbeing services which includes counselling.

5.7 Study limitations

This is a small study that intends to provide relatable insights for paramedics into the benefits and challenges of using counselling. This study is not generalisable to practicing

paramedics in New Zealand and does not include novice practitioners with less than two years' experience and those working as paramedic managers. The decision to use a small number of participants in this study was made because I am a novice researcher and this study is a starting point for my research journey as a paramedic researcher. Thorne (2016) suggests that a small interpretive study is ideal for "practicing clinicians or professionals getting their feet wet in the world of research" (p.264). It is acknowledged that the participants that have volunteered to take part in this research may have been motivated to participate because of a particular interest in this area or a personal agenda around this topic.

Despite efforts being made to ensure accuracy throughout the research process, it is not possible to eliminate personal biases and prior preconceptions when undertaking an ID enquiry (Crotty, 1998; Hunt, 2009; Thorne, 2016). This is because the experience of the participants is discussed through the subjective lens of the researcher (Rubin & Rubin, 2005). For this study I was the primary researcher and the sole person that interacted with the participants during the data collection phase.

5.8   Recommendations for future research

- Further research would be helpful into the perspective and experiences of paramedic managers of using counselling and promoting counselling to their staff.

- It would be of value to undertake a future study to measure the effect that proactive counselling has on the long-term resiliency of new paramedic recruits.

- Research into the benefit and feasibility of clinical supervision/professional supervision for paramedics is needed to see if this can provide a more approachable proactive psychological support for paramedics in addition to EAP counselling.

5.9   Conclusion

This study into the perspective and experiences of ten New Zealand based paramedics who have used counselling has revealed that counselling is a worthwhile and beneficial tool to assist paramedics with managing stress from both within and outside the workplace. The paramedics in this study mostly accessed counselling in a reactive way and demonstrated an

alarmingly high threshold for identifying their need for the service. This threshold was usually a 'breaking point' which often involved significant impairment to their mental health.

Paramedics in this study found it challenging to identify when they should utilise counselling. In many cases it was an accumulation of multifactorial stress that precipitated their need for counselling rather than one particular traumatic incident. Multifactorial stress often included home-life stress. In some instances home-life stress was impacting the work performance of the paramedic.

An unexpected and important finding in this study was that technical aspects of the booking process had the potential to impede access to counselling for some participants. The most significant technical barrier was not having the login name and password required to make an online booking with an externally contracted counselling service. In the context of stigma and high stress, barriers such as this can have significant implications due to a reluctance to ask peers or managers for help. The password example serves as a reminder to organisations to make sure that the counselling services that are offered go through robust and ongoing user testing.

Counselling could be better utilised by paramedics using the service in a more proactive and ongoing manner. For this to happen, ambulance organisations need to work break down existing barriers to access and normalise proactive use of counselling for their staff. In order to reduce stigma and normalise the use of counselling, ambulance managers need to routinely use the counselling services that they offer to their staff so they maintain their mental health as well as role modelling the proactive use of these services. Accessing counselling and other psychological supports should be routine part of safe paramedic practice.

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Appendix A

Employee Assistance Program Brochures

Employee Assistance Programme, St John Ambulance (St John, n.d.-a).

St John
Here for Life

St John
Here for Life

Tell me again how it works?

If you're having difficulties and need some independent help to resolve them, call 0800 284 678. You can talk with a MAP professional, who can assist you with work or personal issues.

Or to book online
go to **www.insteplimited.com**

Login: **insta700**

Password: **stjohn**

Member Assistance Programme

For 24 hour, 7 days a week
confidential advice and support

0800 284678

www.insteplimited.com

i'nstep

For 24 hour, 7 days a week
confidential advice and support

0800284678

www.insteplimited.com

St John | **ASB**

What Member Assistance Programme (MAP) can do for you

From time to time we all face issues which are hard to deal with.

Relationship difficulties, grief, work related stress, financial and legal issues, illness, family problems and alcohol and drug abuse - they're just some of the many stressful things that can come into our daily lives.

Your MAP is a confidential way in which you can seek advice on the things that may be worrying you and which may be affecting your work.

You may have concerns about your work or workmates, or may be worried about things that are happening at home in your family life.

MAP assistance is being offered in the belief that a healthy mind and body, free of major stresses and strains will result in members who are better able to do their job and contribute to the outcomes we're all seeking for St John.

How MAP works

You have 24 hour, 7 days a week access to a 0800 helpline or online bookings via www.insteplimited.com.

The person answering your call has been trained in assessing work, financial, family and relationship problems. They'll listen to you and may be able to help by just talking through things with you.

If they're unable to help you resolve the matter, they may give you some options that will help you get some answers to the issues that are concerning you.

Options including referrals to a psychologist/ counsellor or one of the many volunteer or government support agencies in the community.

Frequently Asked Questions

Q. Who pays for the MAP?

A. A: The MAP is paid for by St John. The service is available to all members. In addition, St John will pay for a specific number of counselling sessions should these be necessary.

Q. Is this programme totally confidential?

A. Yes. No one within St John will know you have asked for assistance unless you tell them or have given consent for Instep to speak to a nominated person in your workplace.

Q. What happens if more than the allocated number of sessions are needed to help?

A. You will be asked to sign a consent form. This gives Instep authority to contact the St John MAP Co-ordinator, who will make the decision to approve additional sessions based on non-identifiable information provided by your counsellor. This request is usually approved as long as there is no indication that the MAP is being abused.

Q. I am a manager and I want materials and resources for my team.

A. A resource pack is available for supervisors and managers. Ask your HR Advisor about how to get hold of these; alternatively contact Instep who will be able to provide you with a list of booklets and brochures.

Q. Does St John receive any reports or information?

A. Yes. Instep provides reports to St John giving statistics on the kinds of issues and the utilisation rate of the MAP. As a responsible employer St John want to know what issues need to be worked on and to be assured St John is getting value and quality of the programme. There is no identification of the individuals.

Q. Can I book MAP online?

A. Yes you can.
Go to **www.insteplimited.com**. Login as **insta700** with the password **stjohn** and use the Online Counsellor Booking function.

Confidential help for:

work and personal relationships

coping with stress

alcohol, drugs and gambling concerns

anxiety and depression

grief and loss

career and retirement planning.

Employee Assistance Programme, Wellington Free Ambulance (Stratos, n.d.).

The Employee Assistance Programme can help with the following personal issues:

stress relationship difficulties family concerns anxiety depression grief loss abuse violence emotional impact of legal or financial difficulties alcohol and substance abuse gambling concerns about physical mental or emotional health communication difficulties overload harassment coping with change restructuring workplace conflict managing staff traumatic event deteriorating performance

» remember, get help now while the problem is still small

WELLINGTON FREE AMBULANCE
kia ora te tangata

wellaware

For more information and to contact a counsellor:

» website
www.stratos-ltd.co.nz
Organisation ID: wfeap
Password: wellaware

» intranet
search EAP
on the WFA intranet
Click the "stratos" link

» phone
0800 STRATOS (787 2867)

» or talk to your
People and Capability team

Stratos
Investing in people

stress relationship difficulties family concerns anxiety depression grief loss abuse violence emotional impact of legal or financial difficulties alcohol and substance abuse gambling concerns about physical mental or emotional health communication difficulties overload harassment coping with change restructuring workplace conflict managing staff traumatic event

employee assistance programme
CONFIDENTIAL | VOLUNTARY | FREE

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employee assistance programme

Wellington Free Ambulance is proud to provide an Employee Assistance Programme (EAP) to employees.

What is an Employee Assistance Programme?

Wellington Free Ambulance recognises that sometimes personal problems can create stress which may be disruptive to your work and/or home life. The organisation wishes to provide professional confidential support so you can find solutions and strategies that will enable you to reach your full potential in both your personal and work life.

Who can use the programme?

Any employee or fixed term contractor (including temporary staff and volunteers) of Wellington Free Ambulance. Their spouse/partner, children/child and other significant dependents living in the same house as the employee can also share the counselling with the employee as agreed with the counsellor.

When would I consider using the programme?

You can use the programme when any personal problem is worrying you to the extent that it is having an impact on your work. You might recognise this yourself. Alternatively a colleague or family member might suggest that you consider getting some support. Signs that you might benefit from counselling could include experiencing a loss of energy, having sleep deprivation, or concentration loss, forgetting things, overreacting or becoming withdrawn.

How big does the problem have to be to use the programme?

You do not have to wait until the problem is "big". We would encourage you to make use of the service to work through your problems or difficulties at the stage you feel it would be helpful.

Do I have to go to counseling if I don't want to?

No. Counselling is entirely voluntary.

How many counselling sessions are available?

The company will pay for up to three (3) sessions with one of the contracted counsellors. If further sessions are required, please discuss this with your counsellor.

What will it cost me?

The counselling is free for up to three (3) sessions. If additional sessions are required, or the counsellor believes that referring you to someone else other than one of the contracted counsellors would provide more appropriate support, they will discuss this with you. The costs in these situations may be your responsibility.

How do I contact a Counsellor?

You are encouraged to contact a counsellor directly. If they are not available because they are counselling you will be able to leave a message. The counsellor will call you back as soon as they are able. When leaving a message please say you work for Wellington Free Ambulance, leave your name and telephone number and the best time to call you back.

How do I find the counsellors' numbers?

There are several ways to find the numbers of the counsellors:

Go to the internet address www.stratos-ltd.co.nz
Company ID: wfaeap   Password: wellaware

You can contact Stratos who provide the programme on 09 538 0261 or 0800 STRATOS (787 2867)

You can contact the Wellington Free Ambulance Executive Manager of People and Capability who can provide you with the phone numbers.

Will my Manager or anyone else know that I am using EAP?

Your manager will only know that you are using EAP is you choose to tell him/ her, or ask for time off to meet with one of the counsellors. If your manager has indicated that they have some concerns about your performance, they may suggest that you would find counselling helpful.

If your work performance remains impaired after normal supervision practices have been followed, or you are potentially a hazard to your own or others health, safety and welfare, your manager can formally refer you to counselling. You can accept or deny this referral; participation in the Programme is voluntary.

Will any information get back to Wellington Free Ambulance?

Counselling sessions are anonymous and confidential. The counsellor will not discuss what took place in counselling with anyone else unless you give them permission to. Unless you tell someone what you have discussed with the counsellor, no one will know.

What happens at counselling?

The counsellor will help you review the reasons you have gone to counselling and then help you look at ways of resolving the issues you are facing. The session will usually last approximately one hour. If the counsellor believes someone else would be more able to help you, he/she will recommend a suitable person. The costs in this instance may be your responsibility.

What happens if I need to cancel the session?

Please give the counsellor at least 24 hours notice if you are unable to attend the session. Otherwise this will be deducted from your three (3) free sessions.

Why will the counsellor ask me to complete an evaluation of the counselling?

This is an important part of the process of reviewing a counsellor's performance. It is also a way of providing feedback (in summarised statistical form only with your identity being unknown) to Wellington Free Ambulance so that they can understand the benefits employees are gaining from counselling. No individual can be identified from the statistics.

Stratos
Investing in people

Appendix B

Auckland University of Technology Ethics Committee (AUTEC) Approval

AUTEC Secretariat

Auckland University of Technology
D-88, WU406 Level 4 WU Building City Campus
T: +64 9 921 9999 ext. 8316
E: ethics@aut.ac.nz
www.aut.ac.nz/researchethics

AUT

17 June 2016

Amanda Lees
Faculty of Health and Environmental Sciences

Dear Amanda

Ethics Application: 16/224 Amanda What are the perspectives and experiences of paramedics that have used employer provided counselling services?

Thank you for submitting your application for ethical review. I am pleased to confirm that the Auckland University of Technology Ethics Committee (AUTEC) has approved your ethics application for three years until 13 June 2019.

As part of the ethics approval process, you are required to submit the following to AUTEC:

- A brief annual progress report using form EA2, which is available online through http://www.aut.ac.nz/researchethics. When necessary this form may also be used to request an extension of the approval at least one month prior to its expiry on 13 June 2019;

- A brief report on the status of the project using form EA3, which is available online through http://www.aut.ac.nz/researchethics. This report is to be submitted either when the approval expires on 13 June 2019 or on completion of the project;

It is a condition of approval that AUTEC is notified of any adverse events or if the research does not commence. AUTEC approval needs to be sought for any alteration to the research, including any alteration of or addition to any documents that are provided to participants. You are responsible for ensuring that research undertaken under this approval occurs within the parameters outlined in the approved application.

AUTEC grants ethical approval only. If you require management approval from an institution or organisation for your research, then you will need to obtain this.

To enable us to provide you with efficient service, we ask that you use the application number and study title in all correspondence with us. If you have any enquiries about this application, or anything else, please do contact us at ethics@aut.ac.nz.

All the very best with your research,

Kate O'Connor
Executive Secretary
Auckland University of Technology Ethics Committee

Cc: Steven Peach; ari.peach@aut.ac.nz

AUTEC Secretariat

Auckland University of Technology
D-88, WU406 Level 4 WU Building City Campus
T: +64 9 921 9999 ext. 8316
E: ethics@aut.ac.nz
www.aut.ac.nz/researchethics

6 December 2016

Amanda Lees
Faculty of Health and Environmental Sciences

Dear Amanda

Re: Ethics Application: 16/224 What are the perspectives and experiences of paramedics that have used employer provided counselling services?

Thank you for your request for approval of amendments to your ethics application.

The amendment to the recruitment protocols and inclusion criteria is approved.

I remind you that as part of the ethics approval process, you are required to submit the following to the Auckland University of Technology Ethics Committee (AUTEC):

- A brief annual progress report using form EA2, which is available online through http://www.aut.ac.nz/researchethics. When necessary this form may also be used to request an extension of the approval at least one month prior to its expiry on 13 June 2019;

- A brief report on the status of the project using form EA3, which is available online through http://www.aut.ac.nz/researchethics. This report is to be submitted either when the approval expires on 13 June 2019 or on completion of the project.

It is a condition of approval that AUTEC is notified of any adverse events or if the research does not commence. AUTEC approval needs to be sought for any alteration to the research, including any alteration of or addition to any documents that are provided to participants. You are responsible for ensuring that research undertaken under this approval occurs within the parameters outlined in the approved application.

AUTEC grants ethical approval only. If you require management approval from an institution or organisation for your research, then you will need to obtain this. If your research is undertaken within a jurisdiction outside New Zealand, you will need to make the arrangements necessary to meet the legal and ethical requirements that apply there.

To enable us to provide you with efficient service, please use the application number and study title in all correspondence with us. If you have any enquiries about this application, or anything else, please do contact us at ethics@aut.ac.nz.

All the very best with your research,

Kate O'Connor
Executive Secretary
Auckland University of Technology Ethics Committee

Cc: ari.peach@aut.ac.nz; Brian Rodgers

Appendix C

Participant Information Sheet

Participant Information Sheet

Date Information Sheet Produced:

31 May 2016

Project Title

What are the perspectives and experiences of paramedics that have used employer provided counselling services?

An Invitation

My name is Ari Peach. I am an intensive care paramedic and a paramedicine lecturer at AUT University. I would like to invite you to participate in my research. This study aims to explore the experience of paramedics using that have used counselling to cope with the well documented stressors and demands of their work. This research will formally complete my Master of Health Science qualification. Your participation in this research is voluntary and you may withdraw at any time prior to the completion of the data collection which is anticipated to be 1st September 2016.

What is the purpose of this research?

The purpose of this research is to describe and interpret the experiences of a small number of paramedics around of their use of counselling. It is intended that the findings of this study will be shared in journal articles and conferences that are applicable to paramedics and other emergency services.

As a participant in this study you will have the opportunity to be involved in paramedic research and contribute to new knowledge. Your experience is valuable and will guide further studies on similar topics.

As I currently lecture on the topic of paramedic mental health and wellbeing, my undertaking of this research will give me the opportunity to incorporate findings into my teaching and share new knowledge with students. I see this study as a good start and a foundation for further research in this subject area.

How was I identified and why am I being invited to participate in this research?

This study has recruited participants through advertising in the St John weekly bulletin and all participant have self selected to be involved. All participants have emailed me their contact details and have been selected on a first come first served basis.

For this study there is are two specific exclusion criterion. The first being an undergraduate paramedic student at AUT due to the power balance of myself being a lecturer, and the second being a paramedic management higher than shift supervisor due to the power balance of them being my manager.

What will happen in this research?

As a participant in this study you I will interview you for 1 hour about your experience of using counselling that has been provided by St John Ambulance. There will be specific set questions and also the freedom to discuss thoughts and experiences that might naturally come about in the interview.

The data from the interviews will be transcribed and your details will be kept strictly confidential. This data will then be interpreted by myself and the ideas and experience from all the participants will be described to enhance the understanding of what the counselling experience is like for paramedics.

What are the discomforts and risks?

It anticipated that there is a small risk that sharing experiences about counselling could bring up emotional upset due to the distressing nature of the incident that may have prompted the initial counselling session. It is important to point out that the interview is focused on what the experience of counselling was like rather than getting in depth account of an actual traumatic incident.

How will these discomforts and risks be alleviated?

The risk of any emotional upset caused by the interview can be supported by 3 free counselling sessions offered by AUT Counselling. There is a formal arrangement that these sessions can be accessed by contacting the AUT Health Counselling and Wellbeing on 09 9219992. As a St John employee you also have available their EAP counselling service if further support is needed.

What are the benefits?

Participating in this study is an opportunity for you to be involved in paramedic research and gain an understanding of what academic research involves. I would be happy to answer any questions about the research process.

It is hoped that this study will benefit all paramedics by enhancing the understanding of what the experience of counselling is like and potentially inform future research. By better understanding what the experience of counselling it is hoped that that further studies can look at ways to better support paramedics and focus on reducing paramedic burnout. This long term goal will benefit the community as less burnt out clinicians make better decisions for their patients.

For myself personally, this study allows me to complete my Master of Health Science qualification. It is hoped that this study will also inform my teaching around paramedic mental health and wellbeing.

How will my privacy be protected?

You will not be identified at any stage to anybody other than the researcher and the supervisor. You will be identified by a pseudonym in all written notes and within the development of the thesis and in the typed transcripts. Privacy of any people that are named in the interview will also be protected by being assigned a letter when being referred to. You are able to chooose a pseudonym if you wish. After the study is completed, data that has been collected and stored will not be able to be accessed by anyone other than the researcher and supervisor and will be stored securely. Interviews are being undertaken at an AUT campus of your choice. St John facilities will not be used to maintain your privacy for the interivew.

What opportunity do I have to consider this invitation?

You have two weeks to consider this invitation.

How do I agree to participate in this research?

To agree to participate in this research, you need to email me expressing your intention to participate. You then will be emailed a consent form to fill in and also be given possible interview times to confirm.

Will I receive feedback on the results of this research?

If you would like a written summary of the findings of this research, there is a selection box on the consent form to request this. These findings will be a 1-2 page document that will be sent to your personal email.

What do I do if I have concerns about this research?

Any concerns regarding the nature of this project should be notified in the first instance to the Project Supervisor, Amanda Lees, *alees@aut.ac.nz*, 09 921 9999 ext 7647.

Concerns regarding the conduct of the research should be notified to the Executive Secretary of AUTEC, Kate O'Connor, *ethics@aut.ac.nz*, 921 9999 ext 6038.

Whom do I contact for further information about this research?

Please keep this Information Sheet and a copy of the Consent Form for your future reference. You are also able to contact the research team as follows:

Researcher Contact Details:

Ari Peach

Email: ari.peach@aut.ac.nz

Phone: 09 021 9999 ext 7849

Project Supervisor Contact Details:

Amanda Lees

Email: alees@aut.ac.nz

Phone: 09 021 9999 ext 7647.

Appendix D

Letter of AUT counselling support for study participants

Memorandum

To	Ari Peach
From	Paul Wedge
cc	
Subject	AUT Counselling services for research participants
Date	31 May 2016

Dear Ari

As the Head of Counselling, AUT Health Counselling and Wellbeing, I would like to confirm that our counselling service is able to offer confidential counselling support for the participants in your AUT research project entitled:

"What are the perspectives and experiences of paramedics that have used employer provided counselling services?"
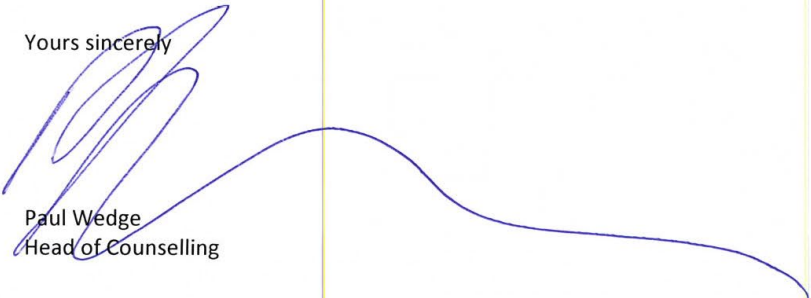
The free counselling, for participants who require it, will be provided by our professional counsellors for a maximum of three sessions, and must be in relation to issues directly arising from their participation in your research project.

Please inform your participants:
- They will need to drop into our centres at WB219 or AS104 or phone 921 9992 City Campus or 921 9998 North Shore campus to make an appointment. Appointments for South Campus can be made by calling 921 9992
- They will need to let the receptionist know that they are a research participant
- They will need to provide your contact details to confirm this
- They can find out more information about our counsellors and counselling on our website http://www.aut.ac.nz/students/student_services/health_counselling_and_wellbeing

Current AUT students also have access to our counsellors and online counselling as part of our normal service delivery.

Yours sincerely

Paul Wedge
Head of Counselling

Email Advertisement for Paramedics Australasia

Paramedic Research

Title: What are the perspectives and experiences of paramedics who have accessed employer provided counselling?

Are you a paramedic or intensive care paramedic?

Have you ever accessed counselling through an your EAP?

We want you!

The emotional toll of paramedic work not only has implications on the paramedic's wellbeing but also their work performance. It is important to develop an understanding of paramedic experiences of counselling as it is one of the main forms of assistance offered to paramedics for coping with work stress and trauma.

An Invitation

Ari Peach and Amanda Lees are conducting research exploring paramedic perspectives and experience with the use of counselling to cope with their work. We would like to invite you to participate in this research project that will involve a confidential one hour, semi structured interview with the researcher Ari Peach.

- We are targeting paramedics based in the North Island of New Zealand
- Participation in this research project is voluntary and you may withdraw at any time
- As a participant your personal details will remain confidential through the entire research process
- Get on board and help lead paramedic centric research in New Zealand

Please share this invitation with your paramedic colleagues!!

If you you would be interested in being involved in this study please email ari.peach@aut.ac.nz

For this study current undergraduate AUT paramedicine students and ambulance mangers who are shift supervisor or higher will not be recruited.

Whom do I contact for further information about this research?

RESEARCHER CONTACT DETAILS:

Ari Peach, ari.peach@aut.ac.nz , 09 921 9999 ext 7849.

PROJECT SUPERVISOR CONTACT DETAILS:

Amanda B Lees, amandab.lees@aut.ac.nz , 09 921 9999 ext 7647

Appendix F

Interview Question Guide

Starting questions

Can you please tell me what your ambulance practice level is and give brief overview of your experience working as a paramedic?

How many times have you accessed counselling through an ambulance service?

Can you tell me about the pattern of accessing counselling during your career (Regular each year? How many sessions used? Different counsellors?)

How did you find out about the counselling service that your ambulance employer offers?

Main questions

What prompted you to seek counselling the first time while employed as paramedic? (Then ask about subsequent times where counselling was accessed)

In your experience were there any barriers to accessing counselling? (What barriers exist for other staff?)

What things made accessing counselling easier?

Can you tell me about your experience of going to counselling for the first time? (How did you feel before, during, after?)
-        Did you learn any specific coping strategies?
-        Were there any specific therapies that you found to be helpful?

What were the other experiences like? (How did you feel before, during, after?)

Did you have enough sessions to meet your needs? (And have enough sessions available to you to meet future needs)

Can you tell me about how you found the counsellor/s that you have seen?
-        Did you choose a male or female counsellor? Was the gender of the counsellor important to you?
-        Did you feel that your counsellor had the qualifications and experience to meet your needs?
-        (If you have seen different counsellors) What was your experience like with the different counsellors? How did it compare?
-        What makes a good counsellor for a paramedic?

Have you shared your experience of going to counselling with any of your paramedic colleagues? (Ask about rationale/reasoning)

Do other paramedics talk about counselling?

What is ambulance culture around accessing psychological support (in particular counselling)?

Do you think you will use counselling again? How do you plan to use counselling in the future? (Ask about rationale/reasoning)

Closing questions – looking ahead

Can you think of any ways which the counselling service that is offered to paramedics in your organisation can be improved?

What advice would you give new paramedic graduates about using counselling services that are available to paramedics?

Do you think that there are any particular events or cases that could require a paramedic to use counselling?