Barriers to seeking help for an emotional or mental health condition among Australian emergency services workers

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Abstract

Not all emergency services workers with a developing mental health condition seek help. Barriers to help-seeking in this population include stigma, being seen as weak, career and confidentiality concerns, and not being able to take time off from work. Barriers are widespread across the sector and appropriate interventions need to be tailored to this population. The literature refers to research mostly undertaken in single sectors or organisations, which this study sought to address by examining data from "Answering the Call", a national study of the mental health and wellbeing of a large cohort of emergency services personnel. We aimed to see if help-seeking barriers could be grouped in some way and, if so, which demographic and psychological factors were associated with those groups. Latent class analysis found people could be grouped according to the number of barriers reported (i.e., lots, some, or a few) but not by the types of barriers reported. Factors associated with reporting lots of barriers included being in the police sector, being male, having severe levels of probable PTSD or psychological distress, low levels of receiving support, and high levels of workplace stress. The most commonly reported barrier was preferring to handle problems on one's own or with family/friends. This implies that the large, complex array of factors affecting people's help-seeking leads to a sense of feeling overwhelmed and preferring to deal with problems on their own. Increased training in mental health literacy for managers, while alleviating career concerns and perceptions of stigma among all personnel, is recommended.

Keywords: *Help-seeking barriers, emergency services workers, mental health, first responders*

Work in the emergency services can be physically and mentally demanding and coupled with the high level of exposure to traumatic events there is an increased risk of mental injury (Jones et al., 2020). That is why access to, and use of, support services for mental health problems is vital. However, not all emergency services workers (ambulance, fire and rescue, police, and state emergency services) with a developing mental health condition seek help in a timely way or even do so at all (Rikkers & Lawrence, 2021). This can be problematic as research shows that, amid an often stressful and traumatic working environment, seeking appropriate help when it is needed leads to the best long-term outcomes (Bacharach & Bamberger, 2007). Barriers to mental health help-seeking in the general population are manifold and complex in nature (Andrade et al., 2014; Vogel et al., 2007), and for emergency services personnel they can be compounded by additional factors including perceptions of stigma and being seen as weak, concerns about career impacts, and difficulty finding time away from work (Chapman et al., 2012, 2014; Fox et al., 2012; Haugen et al., 2017; Hom et al., 2016; Jones et al., 2020). Moreover, the in-house support services available to personnel appear to be the least preferred option for help-seeking (Tamrakar et al., 2020). This large and complex array of barriers is particularly problematic in such an at-risk population, whose rates of post-traumatic stress disorder (PTSD) are twice that of the general population (Kyron et al., 2021).

Tailoring appropriate interventions for emergency services personnel is advised (Kutcher et al., 2016); however, relatively few studies have quantitatively assessed barriers to care in this population, with the majority assessing single sectors or organisations and relatively narrow in scope (Haugen et al., 2017; Jones et al., 2020; Varker et al., 2018). Therefore, we used data recently collected from a large cohort of Australian emergency services workers to examine barriers to help-seeking in a way that might facilitate the design of suitable interventions. "Answering the Call", the

national survey of the mental health and wellbeing of police and emergency services in Australia, was a world-first cross-sectional study which encompassed all four emergency sectors: ambulance, fire and rescue, police, and state emergency services (Beyond Blue Ltd., 2018). The survey captured detailed, wide-ranging mental health and wellbeing information encompassing mental health problems, resilience, social support, workplace risk factors for mental health, perceived need for help, barriers to help-seeking, and service use (Kyron et al., 2021).

We used survey results to test the hypothesis that emergency services employees with a need for mental health care, but not seeking it, would be able to be classified into groups reporting similar types of barriers to help-seeking. We predicted that if it were possible to identify groups reporting similar barriers, it may be possible to target interventions based on characteristics associated with those groups. Using this data, we sought to determine associations between reported barriers and demographic characteristics (i.e., emergency services sector, age, sex, and rank), selected mental health problems (i.e., probable PTSD, psychological distress, and suicidal ideation), levels of social support, and workplace stressors.

Method

Participants and Procedure

The methodology of "Answering the Call", response bias, and demographic statistics of the participants have been previously described in detail (Beyond Blue Ltd., 2018; Kyron et al., 2021). Briefly, 33 out of a possible 36 police, ambulance, fire and rescue, and state emergence service agencies around Australia participated in the online survey. The purposes of the survey were to assess the mental health of employees, identify the associated risk factors, identify barriers to help-seeking, and measure service use. In total, 14,868 employees participated in the survey (Police = 8,088, Ambulance = 3,473, Fire and Rescue = 2,975, State Emergency Service = 332), with an estimated response rate of 22%. Selected demographic characteristics are contained in Appendix 2 (Table A1). The sample was determined to be largely representative of the emergency services population, with slightly higher representation of females and older employees. These and other minor differences were taken into account during the weighting procedure. Ethics approval was obtained from The University of Western Australia Human Research Ethics Committee (RA/4/1/9036).

Measures

Barriers to help-seeking. Respondents who did not seek help or delayed seeking help were asked a 12-item question to assess barriers to help-seeking: "Here is a list of concerns that a person might have when they consider seeking support or treatment for stress, emotional or mental health issues. Please indicate how much you agree or disagree that each of these concerns might have affected your decision whether or not to seek support or treatment". They were offered a list of 12 barriers (I wouldn't know where to get help; I would have difficulty getting time off work to attend a session; I wouldn't be able to do it confidentially; It would harm my career or career prospects; People would treat me differently; I would be seen as weak; It would stop me from doing operational work; I would be seen as a burden to my team or family; I prefer to deal with my problems by myself or with family/friends; I was concerned it would negatively impact on my colleagues; I don't believe that treatments are effective; I don't trust mental health professionals) to which they indicated their level of agreement (1= Strongly disagree, 2 = Disagree, 3 = Neither agree nor disagree, 4 = Agree, 5 = Strongly agree). Participants were considered to have endorsed a barrier to help seeking if they agreed or strongly agreed with that statement.

Diagnosed mental health conditions are dependent on having sought help, and as the purpose of this paper is to examine barriers to help-seeking, we have chosen to focus on the conditions identified through the screening scales included in the survey: post-traumatic stress disorder, psychological distress, and suicidal ideation.

Post-Traumatic Stress Disorder (PTSD). PTSD was assessed using a scale developed for "Answering the Call" and based on the PCL-5 PTSD screening scale (Blevins et al., 2015). Six items from the PCL-5 were used: loss of interest in things you used to enjoy, feeling emotionally distant or cut off from other people, feeling jumpy or easily startled, having difficulty concentrating, having trouble falling or staying asleep, and feeling irritable or having angry outbursts. Additional questions were added to measure functional impairment and severity and duration of symptoms (see Appendix 1 for full scale). This approach was chosen to address three shortcomings of the PCL-5 for use with an emergency services population, and to make it more relevant to the emergency services in the following ways: (i) to be

more sensitive to the impact of cumulative trauma by asking symptom questions in relation to any previous traumatic experience rather than one specific traumatic event; (ii) to add questions about functional impairment to assess DSM-5 Criterion G that "the disturbance(s) cause clinically significant distress or impairment in social, occupational, or other important areas of functioning" (American Psychiatric Association, 2013); and (iii) to provide an assessment of severity, with scores grouped into sub-threshold (i.e., people who have some but not all symptoms required for diagnosis and impairment of functioning), mild, moderate, and severe categories in this study. The scale had good internal consistency in the current survey (α = .89). PTSD, as measured by this scale, is referred to in this paper as probable PTSD as respondents were not formally diagnosed and the scale was created for the purposes of this survey (see Appendix 1 for full details and scoring).

Psychological distress. Psychological distress was measured using the Kessler-10 (K10) scale, which assesses symptoms of depression and anxiety (Kessler et al., 2002). Ten items measured emotional states on a 5-point Likert-type scale (1 = None of the time, 2 = A little of the time, 3 = Some of the time, 4 = Most of the time, 5 = All of the time), with higher psychological distress representing a greater likelihood of experiencing a mental health condition. Responses were grouped using standard cut-off scores from the ABS 2017-18 National Health Survey (Australian Bureau of Statistics, 2018) into low (score 10-15), moderate (score 16-21), high (score 22-29), and very high (score 30-50) categories. The K10 is a widely used and well-validated screening tool that is highly correlated with serious mental illness, including anxiety and depression (Furukawara et al., 2003). The K10 scale had very good internal consistency in the current survey (α = .92).

Suicidal ideation. Six questions were asked to determine whether participants had seriously thought about taking their own life, planned to take their life, or attempted to take their own life, both ever and in the last 12 months (Australian Bureau of Statistics, 2008). Response options included "Yes", "No", and "Prefer not to say" for each question, and respondents were not asked subsequent questions after the first time they chose "Prefer not to say" (see Appendix 1). Approximately 7.5% chose this option at the first question, therefore, the estimates of suicidal ideation from this data likely underestimate the true prevalence of suicidal thoughts and behaviours for this population. Responses for this study were categorised as follows: "Yes" included people who said they had seriously thought about taking their own life in the last 12 months while "No" included people who said "No" or "Prefer not to say".

Perceived need for help. Respondents were asked whether they felt the need for help for any emotional or mental health issues in the previous 12 months (1 = "No, I did not have any emotional or mental health issues", 2 = "No, I had emotional or mental health issues, but did not need any help or support", 3 = "Yes"). If they sought help, they were asked how soon they sought help or treatment for their issue, and once they sought help, how long it took to receive it (1 = Immediately, 2 = Within 1-2 weeks, 3 = Within 3-4 weeks, 4 = Within 1-3 months, 5 = Within 4-6 months, 6 = More than a year after I felt I needed it, 7 = Don't remember).

Social support. Social support was measured using an adapted version of the 2-Way Social Support Scale (Shakespeare-Finch & Obst, 2011). Respondents were asked to think about their support and social networks and how true the following statements were in relation to their life: 1: "I am there to listen to other people's problems"; 2: "My family/friends understand my job demands"; 3: "I like helping others"; 4: "There is someone I can talk to about the pressures in my life"; 5: "There is someone in my life that makes me feel worthwhile"; 6: "I lead a fulfilling life outside work"; 7: "There is someone in my life I can get emotional support from"; 8: "I give others a sense of comfort in times of need"; and 9: "I feel that I have a circle of people who value me". Respondents answered using a 5-point scale (1 = Not at all, 2 = Somewhat true, 3 = Quite true, 4 = Very true, 5 = Always true).

Items 1, 4, 5, 7, 8, and 9 were sourced from the 2-Way Social Support Scale, while items 2, 3, and 6 were created for the survey. Separate measures of giving and receiving social support were created by summing the appropriate items. A total score for receiving social support was created by summing the items 2, 4, 5, 6, 7, and 9, creating a score between 6 and 30. Participants were classified as having low levels of receiving social support if their score was in the range 6 to 12, and high levels if their score was in the range 13 to 30. Similarly, a total score for giving social support was created by summing items 1, 3, and 8, creating a score between 3 and 15. Participants were classified as having low levels of social support if their score was in the range 3 to 6, and high levels if their score was in the range 7 to 15. The adapted scale was shown to have good levels of internal consistency (α = .87).

Workplace stressors. Workplace stressors were based on the Copenhagen Psychosocial Questionnaire (COPSOQ; Pejtersen et al., 2010). Eighteen items were included in the survey but only six items were used in the current study. They were grouped into three categories: Supervisor support ("How often is your manager willing to listen to your problems at work?"; "How often do you get help and support from your manager?"); Emotional exhaustion ("Do you feel that your work drains so much of your energy that it has a negative effect on your private life?"; "Do you feel that your work drains so much of your time that it has a negative effect on your private life?"); and Rewards ("Is your work recognised and appreciated by the management?"; "Are you treated fairly at your workplace?"). For analytical purposes, supervisor support and rewards were reverse scored so that higher scores represent negative experiences. Each item was scored on a scale of 0 to 4 (0 = Never/hardly ever, 1 = Seldom, 2 = Sometimes, 3 = Often, 4 = Always), with the two items for each category added together. The items were then scored as good (score 0-2), moderate (score 3-5), or poor (score 6-8), with poor indicating a high level of stress caused by that item. This scale had acceptable internal consistency in the study (α = .77).

Analytical Approach

The analysis had several stages. First, we examined the prevalence of individual barriers by sector and for emergency services personnel with various markers of distress (high or very high psychological distress, probable PTSD, suicidal ideation). Second, we grouped 10 individual barriers into four conceptual categories containing similar barrier types to examine the frequency of reporting for each category. Any differences referred to in the text have been fully tested, and confidence intervals provided in Appendix 2 where appropriate. We then undertook a latent class analysis to examine if emergency services personnel could be grouped according to their reported barrier(s), either by type or by number.

Barrier groups. A key question was whether respondents could be grouped according to common or similar barrier *type*; therefore, 10 of the barriers were grouped into four different categories of similar type:

- Didn't know how to access ("I wouldn't know where to get help"; "I would have difficulty getting time off work to attend a session");
- Concerned about career impact ("It would harm my career or career prospects"; "People would treat me differently; "I would be seen as weak"; "It would stop me from doing operational work"; "I wouldn't be able to do it confidentially");
- Don't trust mental health treatment ("I don't believe that treatments are effective"; "I don't trust mental health professionals"); and
- Prefer to deal with problems themselves ("I prefer to deal with my problems by myself or with family/ friends").

Only responses of "Agree" or "Strongly agree" were included.

Barrier class. Barrier class relates to the *number* of reported barriers. To investigate patterns associated with barriers to help-seeking, we fitted a latent class analysis model using Mplus Version 7. The optimal number of classes was chosen using the Vuong-Lo-Mendell-Rubin test and the parametric bootstrapped likelihood ratio test. The profile of reported barriers within each class was then examined to assign descriptive labels to each class.

Finally, several logistic regression models were fitted to assess associations between each barrier group and each barrier class and sectors, demographic characteristics (i.e., age and sex), mental health conditions (i.e., probable PTSD severity, psychological distress, and suicidal ideation), social support, and workplace stressors. All analyses were performed using the *surveylogistic* procedure in SAS version 9.4 and confidence intervals were calculated using the method of linearisation in Taylor Series (Wolter, 1985).

Results

Patterns of Reported Barriers to Help-Seeking

There was relative consistency across sectors regarding the patterns of most to least commonly reported barriers (Table 1). High proportions of police employees reported barriers related to concerns about being treated differently or their careers being damaged. Around half of all employees reported stigmatising barriers such as being treated differently (54.1%), negative career impacts (51.6%), or being seen as weak (46.9%).

Employees who perceived barriers to help-seeking in high proportions had high or very high levels of psychological distress (N = 4,414) and probable PTSD (N = 1,388; see Table 1). In particular, they were concerned about being treated differently, their career prospects being harmed, and being seen as weak.

Table 1

Proportion of Employees Needing Help who Reported Each Barrier to Help-Seeking by Sector and Mental Health Condition

Barrier to help-seeking	Sector					Condition		
	Ambulance	Fire and Rescue	Police	SES	**Total**	Probable PTSD	Psychological Distress	Suicidal Ideation
	%	%	%	%	**%**	%	%	%
I prefer to deal with my problems by myself or with family/friends	74.3	75.0	77.5	73.0	**76.6**	76.9	77.2	74.1
People would treat me differently	37.7	47.9	59.3	49.4	**54.1**	73.9	65.0	67.0
It would harm my career prospects	38.2	44.0	56.4	40.6	**51.6**	72.3	62.5	65.3
I would be seen as weak	31.3	38.8	52.3	39.5	**46.9**	69.5	59.2	60.7
I was concerned it would negatively impact on my colleagues	35.3	44.0	49.3	43.1	**46.3**	55.7	54.0	46.9
I wouldn't be able to do it confidentially	32.4	36.8	49.1	34.3	**44.5**	59.3	53.2	50.5
It would stop me from doing operational work	27.5	37.8	48.8	34.6	**43.6**	59.4	51.8	53.2
I would be seen as a burden to my team or family	31.9	37.1	46.3	32.4	**42.6**	65.1	51.6	59.1
I would have difficulty getting time off work	34.2	22.3	35.5	14.3	**33.3**	49.4	42.9	38.3
I don't trust mental health professionals	9.3	9.8	12.7	15.4	**12.5**	19.1	17.1	18.6
I don't believe that treatments are effective	8.0	9.6	14.2	5.7	**12.3**	22.0	15.7	20.2
I wouldn't know where to get help	10.2	12.3	12.8	9.9	**11.7**	15.9	15.2	11.6

Note. SES = State Emergency Service. See Appendix Table A2 for confidence intervals.

Analysis of Groupings by Barrier Type or Barrier Number

We undertook a latent class analysis to see if employees could be grouped according to whether they endorsed similar types of barriers (i.e., barrier group) or numbers of barriers (i.e., barrier class; see Table 2). The latent class analysis revealed that the clusters were evident only in the numbers of barriers chosen rather than revealing any systematic grouping of respondents according to the types of barriers chosen. A three-class solution provided the best fit, based on fit statistics and entropy. For the two-class model entropy was 0.89 and BIC was 73301; for the three-class model, entropy was 0.91 and BIC was 66088; and for the four-class model, entropy was 0.85 and BIC was 65398. Comparing three classes to two classes, both Vuong-Lo-Mendell-Rubin test (VLMR) and the parametric bootstrapped likelihood ratio test (LLRT) indicated improved fit (VLMR p = .0000, LLRT p = .0000), while four classes was not significantly better than three classes (VLMR p = .0838, LLRT p = .072). Respondents could be grouped into those who endorsed lots of barriers (mean = 7.1 barriers), some barriers (mean = 2.1 barriers), or a few barriers (mean = 1.5 barriers). There was no discernible pattern between number of barriers reported (barrier class) and respondents' perceived need for help with an emotional or mental health condition. However, a much higher proportion of respondents who reported lots of barriers felt they did not need help for their condition (25.3% lots of barriers; 13.1% few barriers; Z = 7.47, p < .0001).

Characteristics Associated with Barrier Type or Barrier Number

Similar barriers were grouped into four conceptual categories to determine associations. Over one in 10 (10.6%) employees needing help endorsed all four groups of barriers, while 33.7% reported three of the four groups of barriers. Barrier groups were compared by sector type, age, sex, PTSD severity, level of psychological distress, suicidal ideation, and barrier class. There was very little variation across demographic groups, except for females being less concerned about career impacts (68.8% females; 79.8% males; Z =

9.53, $p < .001$; see Table 3). Across the sectors, more than half (59.2%) of police employees did not know how to access help and had significantly higher levels of concern about career impact (80.7%) than ambulance workers ($Z = 9.18$, $p < .0001$) and fire and rescue workers ($Z = 7.02$, $p < .0001$). Police also had higher levels of lack of trust in mental health treatments (19.2%) than all other sectors (police vs ambulance, $Z = 2.34$, $p = .019$; police vs fire and rescue, $Z = 2.30$, $p = .021$; police vs SES, $Z = 2.62$, $p = .009$). Otherwise, patterns of response were similar across all sectors; therefore, more detailed results are not reported here.

Table 2
Barrier Class Membership by Average Number of Barriers to Help-Seeking, and by Perceived Need for Help

Barrier Class	# Perceived barriers	Perceived need for help: No need for help[a] (*n* = 3,419)	Perceived need for help: Didn't need help[b] (*n* = 1,276)	Perceived need for help: Delayed seeking help (*n* = 1,429)
	Mean	% (CI 95%)	% (CI 95%)	% (CI 95%)
Lots of barriers	7.1	50.4 (48.7-52.2)	25.3 (23.7-26.8)	24.3 (22.7-25.8)
Some barriers	2.1	61.5 (59.6-63.4)	17.1 (15.6-18.6)	21.3 (19.7-22.9)
Few barriers	1.5	59.6 (55.5-63.7)	13.1 (10.3-15.9)	27.3 (23.6-31.0)

Note. [a] Included respondents who had no emotional or mental health issues requiring support.

[b] Included respondents who had an emotional or mental health issue but felt they did not need any help or support.

Higher levels of probable PTSD and suicidal ideation were associated with higher proportions for each barrier group being reported. Those with very high levels of distress mostly reported the barrier of preferring to deal with their problems on their own or with family/friends, with much lower proportions expressed for the other barriers.

Patterns for those reporting high numbers of barriers were markedly different to those reporting few barriers, with much higher numbers across all barrier groups. For example, 99.9% with many barriers reported concerns about career impact compared to only 40.4% of those with few barriers ($Z = 28.4$, $p < .0001$).

To determine predictors for each type of barrier group, separate logistic regression models were fitted with demographic characteristics (i.e., age and sex), sector type, mental health conditions (i.e., probable PTSD, psychological distress, and suicidal ideation), social support measures, and workplace stressors. Predictors did not vary significantly for each barrier group, and we chose not to present these results in detail here because the latent class analysis revealed that it was the numbers rather than the types of barriers that created significant grouping of respondents. The only notable difference in pattern between the barrier groups was for those with severe PTSD, as they were four times more likely to choose concern about impacts on career (OR = 4.42, $p < .001$) but were least likely to prefer to handle problems on their own (OR = 0.79, $p < .001$).

To calculate predictors for barrier class, a regression model was fitted with sector, sex, age, PTSD, psychological distress, social support, and workplace stressors as independent variables. Associations with reporting lots of barriers were found with several demographic characteristics, with police employees (OR = 2.44, $p < .001$) and males (OR = 1.57, $p < .001$) more likely to report lots of barriers, while older employees were the least likely (OR = 0.64, $p < .001$) to report lots of barriers (Table 4). The more severe the level of PTSD or psychological distress, the greater the likelihood of reporting lots of barriers (severe PTSD, OR = 2.76, $p < .001$; very high psychological distress, OR = 2.45, $p < .001$). Similarly, an association was found with low levels of receiving support and reporting lots of barriers. People who reported lots of barriers to help-seeking had high levels of workplace stress, such as poor supervisor support (OR = 1.68, $p < .001$), poor levels of emotional exhaustion (OR = 2.63, $p < .001$), and, in particular, poor reward levels (OR = 3.01, $p < .001$).

Discussion

The main aim of this study was to determine if emergency services workers could be grouped because they reported similar types of barriers for seeking help for an emotional or mental health condition, and if so, what were the demographic and other characteristics common to each group. However, a latent class analysis revealed that it was the numbers of barriers reported, rather than the types of barriers, that was the distinguishing feature between the classes. That is, people could be grouped into those who reported lots of barriers and those who reported only some or a few barriers. The results did not support the hypothesis that people could be grouped according to the types of reported barrier. While there is a small body of Australian literature which focuses on barriers to help-seeking (Haugen et al., 2017), we could not identify other studies either in Australia or

internationally which have examined numbers of barriers in the same way; therefore, we were unable to make comparisons with our findings, and this may indicate that our results are unique.

Factors associated with reporting lots of barriers included being from the police sector, having high levels of probable PTSD and psychological distress, low levels of social support, low levels of supervisor support and recognition, and high levels of emotional exhaustion from work. These organisational barriers illustrate the influence of a negative work environment on mental health outcomes. This finding supports other studies which show links between the development of PTSD and factors such as conflict with management, discrimination, and a lack of support mechanisms including supervisory support (Armstrong et al., 2014; Bacharach et al., 2007; Meyer et al., 2012; Skeffington, 2017). Police workers in particular are known to be at heightened risk of PTSD when they have poor social support and negative work environments (Marmar et al., 2006). The extant literature supports the notion that police are a high-risk population for mental health conditions, are hesitant to source mental health care based on lower levels of mental health literacy, fear losing their careers, and see themselves as needing to be strong in the face of perceived weakness in others (Barocas & Emery, 2017; Flannery, 2015; Reavley et al., 2018). Coupled with severe mental health conditions, which exacerbate feelings of hypervigilance and anger, this combination of factors appears to contribute to a sense of feeling overwhelmed, perhaps resulting in the perception of multiple barriers to help-seeking.

Based on the results from this study, training managers and welfare officers in the behaviours associated with PTSD and psychological distress may be a valuable first step and could assist in the way employees needing help are identified and counselled (Barratt et al., 2018; Burns & Buchanan, 2020). For example, these behaviours may exhibit in anger, avoidance of help-seeking, or lack of acknowledgement of a problem (Andrade et al., 2014), which means providing simple, straightforward, and confidential pathways to support services, while also providing encouragement to do so, is paramount (Burns & Buchanan, 2020; Watson & Andrews, 2018).

We found that similar types of barriers to help-seeking appear to be common across the sectors and are common in single sector studies (Haugen et al., 2017). The implication here is that emergency services workers experience barriers such as career concerns, being seen

Table 3
Key Demographic and Mental Health Characteristics and Barrier Class of Employees Needing Help by Barrier Group

	Barrier Group			
	Didn't know how to access	Concerned about career impact	Don't trust mental health professionals	Prefer to deal with problems themselves
	%	%	%	%
Age group				
Less than 35 years	60.0	72.2	14.9	80.5
35 - 44 years	55.0	77.0	17.7	75.6
45 - 54 years	53.3	76.8	17.0	74.5
55 years or over	45.9	73.4	16.7	73.7
Sex				
Male	56.3	79.8	19.5	76.6
Female	50.5	68.8	12.6	74.9
PES Sector				
Ambulance	52.3	67.8	13.9	75.5
Fire and rescue	42.6	70.2	13.9	72.4
Police	59.2	80.7	19.2	77.3
State emergency service	42.9	73.8	10.3	74.6
PTSD Severity				
None	48.8	70.7	14.0	75.7
Sub-threshold	63.2	83.7	19.3	75.5
Mild	65.7	88.6	26.3	76.6
Moderate	71.8	87.7	25.5	79.5
Severe	78.2	95.2	32.8	75.5
Kessler 10 scale - ABS categories				
Low	36.3	60.8	9.0	70.1
Moderate	51.0	73.3	14.1	77.7
High	61.9	82.0	19.3	77.4
Very high	70.8	88.0	29.7	75.9
Suicidal ideation				
No	53.1	74.4	15.7	75.9
Yes	63.7	86.3	28.7	75.3
Barrier class				
Few barriers	16.9	40.4	5.0	58.0
Some barriers	29.6	53.4	7.4	69.8
Lots of barriers	80.9	99.9	26.5	84.2

Note. See Appendix 2 Table A3 for confidence intervals.

as weak, lack of mental health literacy, and a desire to self-manage in similar ways, regardless of role or organisation type. The most commonly expressed barrier across all sectors, demographic characteristics, and mental health conditions was the preference to handle problems on one's own or with family/friends, consistent with well-established findings in the literature (Andrade et al., 2014; Gulliver et al., 2019; Shi et al., 2020). There is a paucity of research into the factors associated with this barrier (Haugen et al., 2017), and this study did not identify any strongly linked factors.

When viewed with our other finding that lots of barriers were commonly reported, it is possible that some people feel a sense of helplessness in the face of so many perceived obstacles and, therefore, avoid formal help-seeking entirely, preferring to handle their problems on their own. At face value, this particular barrier could also mean a rejection or cynicism towards professional or clinical advice or treatment (Hom et al., 2017). However, it could also be reflective of perceived stigma, whereby emergency services workers believe that others would perceive mental ill health as weakness (Carleton et al., 2020), even though they do not actually believe that

Table 4
Predictors of Barrier Class Membership by Selected Characteristics

Effect	Barrier Class		
	Lots of barriers	Some barriers	Few barriers
	Point Estimate (SE, CI 95%)	Point Estimate (SE, CI 95%)	Point Estimate (SE, CI 95%)
Sector			
Fire and rescue vs Ambulance	1.37 (0.11, 1.10-1.71)	0.81 (0.11, 0.65-1.00)	0.90 (0.18, 0.64-1.28)
Police vs Ambulance	2.44 (0.08, 2.01-2.85)	0.53 (0.08, 0.46-0.62)	0.59 (0.13, 0.45-0.77)
State emergency service vs Ambulance	1.27 (0.22, 0.82-1.96)	0.80 (0.21, 0.53-1.20)	0.99 (0.36, 0.45-2.02)
Sex			
Male vs Female	1.57 (0.08, 1.34-1.84)	0.77 (0.08, 0.66-0.90)	0.63 (0.13, 0.49-0.81)
Age			
35 - 44 years vs less than 35 years	1.06 (0.11, 0.86-1.31)	1.10 0.10, 0.90-1.35)	0.65 (0.17, 0.47-0.91)
45 - 54 years vs less than 35 years	0.94 (0.10, 0.77-1.15)	1.20 (0.10, 0.98-1.46)	0.72 (0.16, 0.52-0.99)
55 years or over vs less than 35 years	0.64 (0.13, 0.50-0.83)	1.69 (0.12, 1.33-2.15)	0.78 (0.19, 0.54-1.14)
PTSD Severity			
Mild vs None	1.17 (0.16, 0.86-1.59)	0.87 (0.15, 0.64-1.17)	0.82 (0.33, 0.43-1.57)
Moderate vs None	1.82 (0.22, 1.49-2.36)	0.61 (0.22, 0.40-0.94)	0.37 (0.61, 0.11-1.24)
Severe vs None	2.76 (0.28, 1.58-4.81)	0.33 (0.30, 0.18-0.59)	0.83 (0.55, 0.28-2.44)
K10 Category			
Moderate vs Low	1.34 (0.11, 1.08-1.65)	0.96 (0.10, 0.78-1.16)	0.67 (0.15, 0.50-0.90)
High vs Low	1.88 (0.12, 1.49-2.36)	0.74 (0.11, 0.59-0.92)	0.52 (0.18, 0.36-0.74)
Very high vs Low	2.46 (0.16, 1.78-3.39)	0.57 (0.16, 0.42-0.78)	0.41 (0.34, 0.21-0.80)
Social Support Scale			
High giving and low receiving vs High giving and receiving	1.64 (0.15, 1.22-2.21)	0.67 (0.15, 0.50-0.90)	0.68 (0.34, 0.35-1.32)
Low giving and high receiving vs High giving and receiving	0.92 (0.14, 0.70-1.20)	1.25 (0.13, 0.97-1.62)	0.51 (0.27, 0.30-0.87)
Low giving and low receiving vs High giving and receiving	1.31 (0.20, 0.88-1.95)	0.94 (0.19, 0.64-1.37)	0.17 (0.61, 0.05-0.58)
Workplace stressors (COPSOQ)			
Supervisor Support: Moderate vs Good	1.24 (0.09, 1.04-1.48)	0.98 (0.09, 0.82-1.16)	0.62 (0.15, 0.46-0.82)
Supervisor Support: Poor vs Good	1.68 (0.12, 1.32-2.14)	0.66 (0.12, 0.52-0.83)	0.81 (0.23, 0.51-1.28)
Emotional Exhaustion: Moderate vs Good	1.84 (0.10, 1.52-2.23)	0.73 (0.09, 0.61-0.87)	0.60 (0.14, 0.46-0.78)
Emotional Exhaustion: Poor vs Good	2.63 (0.12, 2.10-3.29)	0.50 (0.11, 0.41-0.63)	0.52 (0.22, 0.34-0.80)
Rewards: Moderate vs Good	1.79 (0.10, 1.47-2.17)	0.85 (0.09, 0.71-1.02)	0.46 (0.14, 0.35-0.61)
Rewards: Poor vs Good	3.01 (0.15, 2.26-4.01)	0.56 (0.14, 0.42-0.73)	0.24 (0.33, 0.12-0.45)

Note: The degrees of freedom in computing the confidence limits is 6,123.

themselves (Barocas & Emery, 2017; Halbesleben et al., 2007). Other studies confirm that fear of workplace discrimination (Corrigan & Wassel, 2008) due to the associated fear of being seen as weak (Carleton et al., 2020; Hom et al., 2017; Skogstad, et al., 2013) prevents people from disclosing a mental health issue. This perceived weakness in emergency services workers might be seen as career-limiting given the nature of their roles (Barratt et al., 2018), especially for police whose culture celebrates personal strength and self-reliance, which is counterintuitive to expressing the need for help (Burns & Buchanan, 2020). Our findings support this view, with concerns related to career impact being cited as a barrier by almost all of those who also endorsed many barriers, as well as being linked to the barrier of wanting to handle problems on one's own or with family/ friends.

Interventions based on alleviating concerns about career impacts, as well as changing organisational culture and practice to ensure these impacts are minimised, could be effective (Barratt et al., 2018). Finding ways to ensure a realistic career path both post-mental health condition and also during treatment may reduce career concerns (Skogstad et al., 2013), but will rely on organisations allocating sufficient resources to allow personnel to reduce hours or change functional roles as required. This presents financial challenges, but these may be balanced against the savings in training investment and in reduced workers' compensation claims.

Limitations

The current study used cross-sectional data; therefore, causal relationships cannot be determined. For example, it cannot be determined whether the presence of a mental health condition led to the endorsement of types or numbers of barriers to help-seeking or whether the lack of help-seeking led to the mental health condition. In addition, self-reported screening scales were used to determine mental health conditions, rather than clinical interviews. Although the response rate was relatively low (22%), a post-enumeration analysis showed the sample to be largely representative of the emergency services population in the participating agencies (Beyond Blue Ltd., 2018) and any minor differences were accounted for in the weighting process. Further, this study was conducted in Australia and results may not be applicable in other countries or contexts.

Conclusion

Emergency services workers needing help for emotional or mental health problems but who did not seek help, or did not seek help in a timely way, could be grouped into those who reported either lots of or a few barriers to mental health help-seeking. Specific factors associated with reporting a lot of barriers included being from the police sector, having high levels of probable PTSD and psychological distress, low levels of social support, low levels of supervisor support and recognition, and high levels of emotional exhaustion from work. Although people could not be grouped by the types of barriers reported per se, the pattern in barrier reporting was similar across all emergency services sectors, with the preference to handle problems on one's own or with family/friends the most commonly reported barrier, supporting previous literature.

An important first step is the need to train managers and welfare officers in the behaviours associated with PTSD and psychological distress (Barratt et al., 2018). Alleviating concerns about career impact after disclosure and the introduction of simple, confidential pathways to support are also indicated. The complex array of factors affecting help-seeking in this population makes targeted solutions elusive and difficult (Jones et al., 2020). While specific interventions have been suggested previously, interventions which are more holistic in nature, taking account of the interplay of the many contributing factors rather than simply focussing on one at a time, may be preferable for those feeling overwhelmed by the many perceived obstacles to finding help.

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Appendix 1

Measures used in 'Answering the Call'

Barriers to help-seeking

Q. Here is a list of concerns that a person might have when they consider seeking support or treatment for stress, emotional or mental health issues. Please indicate how much you agree or disagree that each of these concerns might have affected your decision whether or not to seek support or treatment.

(1- strongly disagree; 2- disagree; 3- neither agree nor disagree; 4- agree; 5- strongly agree)

a. I wouldn't know where to get help
b. I would have difficulty getting time off work to attend a session
c. I wouldn't be able to do it confidentially
d. It would harm my career or career prospects
e. People would treat me differently
f. I would be seen as weak
g. It would stop me from doing operational work
h. I would be seen as a burden to my team or family
i. I prefer to deal with my problems by myself or with family/friends
j. I was concerned it would negatively impact on my colleagues
k. I don't believe that treatments are effective
l. I don't trust mental health professionals

Probable PTSD Screener

1) Have you ever experienced a stressful event or series of events either at work or away from work that deeply affected you? (Mark all that apply.)
   1 - No [SINGLE]
   2 - Yes, at work in the police and emergency services sector
   3 - Yes, at work outside the police and emergency services sector
   4 - Yes, away from work

Below is a list of reactions that people sometimes have in response to very stressful experiences. Thinking of stressful experiences that may have occurred either at work or away from work at any stage of your life, please read each statement and indicate how much you have been bothered by that problem in the past four weeks.

2) In the past four weeks, how much were you bothered by …
   a. Repeated, disturbing, and unwanted memories or nightmares about any stressful experiences?
   b. Experiencing flashbacks where you suddenly feel or act as if a stressful experience were actually happening again?
   c. Feeling very upset or experiencing strong physical reactions such as heart pounding, having trouble breathing when something reminded you of these stressful experiences?

   1 - Not at all
   2 - A little bit
   3 - Moderately
   4 - Quite a lot
   5 - Extremely

IF 3, 4, 5 to any of 2a, to 2c, THEN ASK.

3) How often do these reactions occur?
   1 - Less than once a month
   2 - 1-2 times a month
   3 - 3-5 times a month
   4 - 6-10 times a month
   5 - More than 10 times a month

4) How much effort do you make to avoid thinking or talking about any stressful events, or doing things which remind you of stressful experiences?
   1 - None
   2 - A little bit
   3 - Moderate
   4 - Quite a lot
   5 - A great deal

ASK ALL

Still thinking about your reactions to any stressful experiences that may have occurred either at work or away from work, please read each statement below and indicate how much you have been bothered by that problem in the past four weeks.

5) In the past four weeks, how much were you bothered by
   a. Loss of interest in things that you used to enjoy?
   b. Feeling emotionally distant or cut off from other people?
   c. Feeling jumpy or easily startled?
   d. Having difficulty concentrating?
   e. Having trouble falling or staying asleep?
   f. Feeling irritable or having angry outbursts?

   1 - Not at all
   2 - A little bit
   3 - Moderately
   4 - Quite a lot
   5 - Extremely

IF 3, 4, 5 TO ANY OF 5a-5f, THEN ASK.

6) How much distress did these feelings or reactions cause you?
   1 - None
   2 - Mild
   3 - Moderate
   4 - Severe
   5 - Very severe

7) How much did these feelings or reactions disrupt or interfere with your normal daily life?
   1 - Not at all
   2 - A little
   3 - Some
   4 - A lot
   5 - Extremely

IF 3, 4, 5 TO EITHER 6 OR 7, THEN ASK.

8) How long have these feelings or reactions been troubling you?
1 - Less than a month
2 - 1 - 2 months
3 - 3 - 6 months
4 - 7 - 12 months
5 - 1-2 years
6 - 3-5 years
7 - More than 5 years

Scoring

DSM-5 defines 7 symptom clusters for PTSD:

A. Exposure to traumatic event (includes repeated or extreme exposure to aversive details of traumatic events in first responders).
B. The traumatic event is persistently re-experienced.
C. Persistent avoidance of stimuli associated with the trauma.
D. Negative alterations in cognitions and mood associated with the traumatic event.
E. Marked alterations in arousal or reactivity.
F. Duration of the disturbance is more than one month.
G. The disturbance causes clinically significant distress or impairment of functioning.

Cluster A: Respondents were considered to have met cluster A if they answered 2, 3, or 4 to Question 1 or 4 or 5 to Question 4.

Cluster B: Respondents were considered to have met cluster B if they answered 3, 4, or 5 to one or more of Questions 2a, 2b, or 2c.

Cluster C: Respondents were considered to have met cluster C if they answered 3, 4 or 5 to Question 4.

Cluster D: Respondents were considered to have met cluster D if they answered 3, 4, or 5 to either Question 5a or 5b.

Cluster E: Respondents were considered to have met cluster E if they answered 3, 4, or 5 to at least two of 5c, 5d, 5e, or 5f.

Cluster F: Respondents were considered to have met cluster F if they answered 2, 3, 4, 5, 6, or 7 in Question 8.

Cluster G: Respondents were considered to have met cluster G if they answered 3 in both Question 6 and Question 7 or if they answered 4 or 5 to both Questions 6 and 7.

Respondents were considered to have probable PTSD if they met the criteria for all of the clusters A-G.

Suicidal Ideation

SB01. Have you ever felt that life was not worth living?

1 - No
2 - Yes
3 - Prefer not to say

SB02. Have you ever seriously thought about taking your own life?

1 - No
2 - Yes
3 - Prefer not to say

IF SB02=2, THEN ASK.

SB03. Have you seriously thought about taking your own life in the last 12 months?

1 - No
2 - Yes
3 - Prefer not to say

SB04. Have you ever made a plan to take your own life?

1 - No
2 - Yes
3 - Prefer not to say

IF SB04=2, THEN ASK.

SB05. Did you make a plan to take your own life in the last 12 months?

1 - No
2 - Yes
3 - Prefer not to say

IF SB05 = 2, 3 show help message before beginning section WE

SB06. Have you ever attempted to take your own life?

1 - No
2 - Yes
3 - Prefer not to say

IF SB06=2, THEN ASK.

SB07. Have you attempted to take your own life in the last 12 months?

1 - No
2 - Yes
3 - Prefer not to say

Appendix 2: Supplementary Tables

Table A1
Demographic Characteristics of Answering the Call Survey Population

	Ambulance (%)	Fire and rescue (%)	Police (%)	State emergency service (%)	Total (%)
Sex					
Male	53.2	83.3	62.6	45.3	64.1
Female	46.8	16.7	37.4	54.7	35.9
Age group					
Less than 35 years	33.4	20.3	27.9	17.1	27.5
35 - 44 years	25.8	24.6	31.7	28.0	29.7
45 - 54 years	25.2	32.6	28.8	34.0	28.8
55 years or over	15.7	22.6	11.6	20.8	14.0
Role					
Operational	74.2	64.9	62.3	15.7	64.2
Non-operational	14.2	13.5	23.2	26.6	20.3
Both operational and non-operational	11.6	21.6	14.5	57.8	15.4
Length of service in organisation					
Less than 12 months	6.9	3.3	4.6	10.3	4.8
1-2 years	8.4	6.7	6.8	11.6	7.0
3-5 years	16.0	12.2	12.7	19.9	13.2
6-10 years	22.0	16.8	16.4	18.0	17.4
More than 10 years	46.8	61.0	59.6	40.2	57.6
Marital status					
Single	14.1	8.4	11.7	13.4	
Married/De facto	77.3	82.7	78.1	74.2	
Widowed, separated, or divorced	8.5	8.9	10.2	12.4	
Highest educational qualification					
Secondary school to Year 12	6.4	15.5	18.9	12.0	
Certificate III/IV	8.3	38.3	11.6	22.6	
Diploma	25.1	22.2	34.2	25.8	
Bachelor degree	40.8	13.3	22.9	19.8	
Postgraduate qualification	19.4	10.8	12.4	19.7	

Note. Group ns: Ambulance = 3,473, Fire and Rescue = 2,975, Police = 8,088, State Emergency Service = 332.

Table A2

Confidence Intervals for Proportion of Employees Needing Help who Reported Each Barrier to Help-Seeking by Sector and Mental Health Condition

	Sector					Condition
Barrier	Ambulance	Fire and rescue	Police	State emergency service	Total	PTSD
	95% CI	95% CI	95% CI	95% CI	95% CI	95% CI
I prefer to deal with my problems by myself or with family/friends	(71.9 - 76.8)	(71.6 - 78.3)	(75.8 - 79.3)	(64.2 - 81.4)	(75.2 - 78.0)	(73.1- 80.5)
People would treat me differently	(35.1 - 40.4)	(43.9 - 51.8)	(57.2 - 61.4)	(40.6 - 59.0)	(52.5 - 55.7)	(70.2 - 77.5)
It would harm my career or career prospects	(35.5 - 40.8)	(40.1 - 47.9)	(54.3 - 58.5)	(31.9 - 49.9)	(49.9 - 53.2)	(68.6 - 76.0)
I would be seen as weak	(28.8 - 33.8)	(35.0 - 42.6)	(50.2 - 54.5)	(29.9 - 48.1)	(45.2 - 48.5)	(65.6 - 73.4)
I was concerned it would negatively impact on my colleagues	(32.7 - 38.0)	(40.1 - 47.9)	(47.2 - 51.5)	(33.6 - 51.6)	(44.6 - 47.9)	(51.4 - 60.0)
I wouldn't be able to do it confidentially	(29.9 - 35.0)	(33.0 - 40.6)	(46.9 - 51.3)	(25.9 - 43.3)	(42.9 - 46.2)	(55.1 - 63.6)
It would stop me from doing operational work	(25.1 - 29.9)	(34.0 - 41.6)	(46.6 - 50.9)	(25.4 - 42.7)	(42.0 - 45.3)	(55.2 - 63.7)
I would be seen as a burden to my team or family	(29.3 - 34.5)	(33.3 - 40.9)	(44.2 - 48.5)	(23.0 - 40.7)	(40.9 - 44.2)	(61.0 - 69.2)
I would have difficulty getting time off work	(31.6 - 36.8)	(19.1 - 25.5)	(33.4 - 37.6)	(7.4 - 21.4)	(31.7 - 34.9)	(45.0 - 53.7)
I don't trust mental health professionals	(6.6 - 9.5)	(7.4 - 11.8)	(12.6 - 15.7)	(1.3 - 8.4)	(11.3 - 13.6)	(15.6 - 22.6)
I don't believe that treatments are effective	(8.6 - 11.9)	(9.6 - 15.0)	(11.4 - 14.3)	(4.1 - 14.1)	(11.2 - 13.4)	(18.4 - 25.7)
I wouldn't know where to get help	(7.7 - 10.9)	(7.4 - 12.2)	(11.2 - 14.1)	(7.7 - 21.6)	(10.6 - 12.8)	(12.6 - 19.2)

Table A3
Confidence Intervals for key Demographic and Mental Health Characteristics and Barrier Class of Employees Needing Help by Barrier Group

	Barrier group							
	Didn't know how to access		Concerned about career impact		Don't trust mental health professionals		Prefer to deal with problems themselves	
	%	95% CI	%	95% CI	%	95% CI	%	95% CI
Age								
Less than 35 years	60.0	(57.2 - 62.7)	72.2	(69.7 - 74.7)	14.9	(12.9 - 16.9)	80.5	(78.3 - 82.7)
35 - 44 years	55.0	(52.6 - 57.3)	77.0	(75.0 - 79.0)	17.7	(15.9 - 19.5)	75.6	(73.6 - 77.6)
45 - 54 years	53.3	(51.2 - 55.4)	76.8	(75.0 - 78.5)	17.0	(15.4 - 18.5)	74.5	(72.6 - 76.3)
55 years or over	45.9	(42.7 - 49.1)	73.4	(70.6 - 76.3)	16.7	(14.3 - 19.1)	73.7	(70.8 - 76.5)
Sex								
Male	56.3	(54.7 - 57.9)	79.8	(78.5 - 81.1)	19.5	(18.2 - 20.7)	76.6	(75.2 - 77.9)
Female	50.5	(48.5 - 52.5)	68.8	(67.0 - 70.7)	12.6	(11.3 - 13.9)	74.9	(73.2 - 76.6)
PES Sector								
Ambulance	52.3	(49.8 - 54.9)	67.8	(65.4 - 70.2)	13.9	(12.1 - 15.7)	75.5	(73.3 - 77.7)
Fire and rescue	42.6	(39.8 - 45.4)	70.2	(67.6 - 72.8)	13.9	(11.9 - 15.9)	72.4	(69.8 - 74.9)
Police	59.2	(57.5 - 60.9)	80.7	(79.3 - 82.0)	19.2	(17.9 - 20.6)	77.3	(75.9 - 78.8)
State emergency service	42.9	(34.2 - 51.5)	73.8	(66.1 - 81.5)	10.3	(5.0 - 15.6)	74.6	(67.0 - 82.2)
PTSD Severity								
None	48.8	(47.3 - 50.2)	70.7	(69.4 - 72.1)	14.0	(12.9 - 15.0)	75.7	(74.4 - 77.0)
Sub-threshold	63.2	(60.0 - 66.3)	83.7	(81.3 - 86.1)	19.3	(16.8 - 21.9)	75.5	(72.7 - 78.3)
Mild	65.7	(61.1 - 70.3)	88.6	(85.6 - 91.7)	26.3	(22.1 - 30.6)	76.6	(72.5 - 80.7)
Moderate	71.8	(65.9 - 77.8)	87.7	(83.4 - 92.1)	25.5	(19.7 - 31.2)	79.5	(74.2 - 84.9)
Severe	78.2	(72.8 - 83.5)	95.2	(92.4 - 98.0)	32.8	(26.7 - 38.8)	75.5	(70.0 - 81.1)
Kessler 10 scale - ABS categories								
Low	36.3	(33.5 - 39.0)	60.8	(58.0 - 63.5)	9.0	(7.4 - 10.6)	70.1	(67.5 - 72.7)
Moderate	51.0	(48.9 - 53.1)	73.3	(71.5 - 75.1)	14.1	(12.6 - 15.5)	77.7	(76.0 - 79.4)
High	61.9	(59.7 - 64.1)	82.0	(80.3 - 83.7)	19.3	(17.6 - 21.1)	77.4	(75.5 - 79.3)
Very high	70.8	(67.6 - 73.9)	88.0	(85.7 - 90.2)	29.7	(26.6 - 32.9)	75.9	(72.9 - 78.9)
Suicidal ideation								
No	53.1	(51.8 - 54.4)	74.4	(73.3 - 75.6)	15.7	(14.7 - 16.6)	75.9	(74.8 - 77.1)
Yes	63.7	(59.4 - 67.9)	86.3	(83.3 - 89.4)	28.7	(24.7 - 32.7)	75.3	(71.5 - 79.1)
Barrier class								
Few barriers	16.9	(13.8 - 20.0)	40.4	(36.3 - 44.5)	5.0	(3.2 - 6.8)	58.0	(53.9 - 62.1)
Some barriers	29.6	(27.8 - 31.4)	53.4	(51.4 - 55.3)	7.4	(6.4 - 8.4)	69.8	(68.0 - 71.5)
Lots of barriers	80.9	(79.5 - 82.3)	99.9	(99.8 - 100.0)	26.5	(25.0 - 28.1)	84.2	(82.9 - 85.5)