



Curtin University

Report to the Department of Health (Government of Western Australia)

Establishing a Sustainable Road Trauma Support Service in Western Australia

2011 Final Report

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2.0 EXECUTIVE SUMMARY

Psychosocial and economic consequences of road traffic crashes

Despite progress in road safety, crashes are a leading cause of death in Australia and the potential for psychological distress following a major crash is significant. Drivers, passengers, family, friends, colleagues, witnesses, emergency service workers, and even entire communities are affected by every serious crash. Psychosocial consequences may include serious physical injuries and temporary or permanent disability, intense grief, post-trauma reactions, psychiatric disorders, social isolation and stigma, decreases in quality of life, restricted opportunities for leisure, carer burden, and considerable financial costs. Estimates show that road traffic crashes and their consequences cost Australia between \$27 billion and \$344 billion per year.

Services and supports for people affected by road traffic crashes in WA

Despite the clear psychosocial ramifications of road traffic crashes, there is no dedicated road trauma support service in Western Australia (WA) and there are considerable gaps and limitations in the current system of services. Existing supports and services are inadequate in meeting the varied needs of people affected by road traffic crashes because appropriate supports are difficult to identify and costly to access, limited due to time delays or staffing resources, and available only in certain regions rather than state-wide. Thus, the psychosocial consequences of crashes remain largely unsupported in WA. A road trauma support service in WA is urgently required to provide sustainable, coordinated, timely, and appropriate peer support and professional therapeutic interventions for road trauma victims, family members, witnesses, and for others who are adversely affected by road trauma.

Efficacy of support interventions for trauma and bereavement

Mental health research indicates that post-trauma supports and services (peer support and professional interventions) can be very effective in helping people cope with their losses and in promoting optimal vocational, familial, and social functioning following a traumatic event. However, the offer of universal professional support to people affected by road traffic crashes, irrespective of need, is not likely to be effective (or economical). A public health approach to the road trauma support service provides an evidence-base for the allocation of appropriate resources in meeting the needs of people affected by road traffic crashes in WA. Additionally, the community counselling model provides an exemplar for service delivery that combines direct and indirect services to individuals and communities.

Method of investigation

The research project was funded by the Department of Health. A stakeholder reference group consisting of representatives from government and non-government agencies as well as community members affected by road trauma was formed. The group met three times – November 2010, June 2011, and September 2011 and was instrumental in guiding this assessment of the establishment of a sustainable road trauma support service in WA.

Road trauma support services elsewhere in Australia

Existing road trauma supports and services available in other Australian jurisdictions were examined to inform the establishment of a road trauma support service in WA. These

services were – Road Trauma Support Service (Victoria), Road Trauma Services Queensland, Road Trauma Support Team of South Australia, Road Trauma Support Tasmania, Enough is Enough, TrueLight Foundation, Motor Vehicle Fatality Support Program, and the Trans-Help Foundation. Three of these services were then visited by the first author to see firsthand the premises and resources and to talk to staff about each service. These services, chosen in consultation with the stakeholder reference group, were the Road Trauma Support Service (Victoria), Road Trauma Support Team of South Australia, and Road Trauma Support Tasmania.

Recommendations

The analysis revealed that each of these services has strengths and limitations, and informed the recommendations for establishing a road trauma support service in WA. Twenty-two recommendations were proposed:

1. A road trauma support service be established for WA;
2. The road trauma support service be funded by the Government of WA;
3. The road trauma support service be comprehensive and provide services on a state-wide basis;
4. The service's peer support services be advertised and promoted on a state-wide basis;
5. The road trauma support service be delivered according to service need;
6. The road trauma support service should be provided with no charge to clients;
7. The road trauma support service provides preventative education services;
8. The road trauma support service links with appropriately-trained trauma and bereavement therapists to provide professional psychotherapeutic interventions;
9. The road trauma support service facilitates appropriately-trained volunteers to provide non-specialist supports;
10. The road trauma support service includes a suite of complementary direct and indirect services;
11. The road trauma support service be established as a non-profit organisation;
12. The road trauma support service be governed a Board of Management;
13. The road trauma support service utilise a high-profile and appropriately-sensitive Patron;
14. The road trauma support service has a core salaried staff;
15. The road trauma support service be situated in community-based premises accessible by public transport;
16. The road trauma support service be complemented by information packages, a brochure, and a website;
17. The road trauma support service has an initial annual budget and ongoing funding;
18. The road trauma support service has an evaluation and reporting framework;
19. The road trauma support service be established in incremental steps commencing as soon as possible to be in operation by the end of 2012;
20. The road trauma support service be linked and work in partnership with other services and supports;
21. The road trauma support service meet the access needs of underserved groups including culturally and linguistically diverse people, Indigenous Australians, and people with disabilities; and

22. The road trauma support service be complemented by best-practice death notification and the re-establishment of a Family Liaison Officer in WA Police's Major Crash section.

The recommended service arrangement provides sustainable peer support and professional therapeutic interventions for road trauma victims, family members, and for witnesses and others who are adversely affected by road traffic crash events in WA.

This report provides an original, contextual, and data-driven account of (a) the consequences of road crashes, (b) current services in WA, (c) trauma and bereavement service delivery, and (d) existing road trauma support services available in other Australian states. Attempts were made to ensure the process was as rigorous as possible, including the using multiple sources of data and conducting the research in a team. The project's key strength is the involvement of the stakeholder reference group – its members including representatives from relevant services as well as people affected personally by road trauma; this diversity and depth enhances the study's ability to contribute to practice. Further, the report provides the basis for the development and evaluation of the future road trauma support service in WA.

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3.0 PSYCHOSOCIAL AND ECONOMIC CONSEQUENCES OF ROAD TRAFFIC CRASHES

Traffic crash fatalities remain a significant global health issue resulting in a considerable number of deaths per year. In 2004 the World Health Organization launched its *World Report on Road Traffic Injury Prevention* and dedicated its World Health Day to road safety. Almost 1.2 million people are killed, and between 20 and 50 million are injured, in traffic crashes every year worldwide and the number of deaths and injuries is expected to increase by 65% by 2020¹. Road traffic crashes are the ninth leading cause of the global burden of disease and it is estimated that they will be the sixth leading cause of death by 2020 (accounting for 3.4% of all deaths)².

Despite progress in road safety, crashes are a leading cause of death in Australia, particularly for vulnerable road users such as people in younger age groups and Indigenous Australians^{3,4,5}. The road crash fatality rate per 100,000 in Western Australia (WA) is higher than the national average^{6,7}. Table 1 shows the number of crash fatalities in WA since 2005. In addition to the fatalities, there are approximately 2800 serious injuries resulting from road crashes every year in WA⁸.

Table 1
*Road Traffic Crash Fatalities in WA 2005-2011*⁹

Year	Fatalities
2005	164
2006	201
2007	236
2008	207
2009	193
2010	193
2011	128

The potential for psychological distress following a major crash is significant. Approximately 13 people are significantly affected by every fatal crash¹⁰ and these include family, friends, colleagues, witnesses, emergency service workers, and even entire communities¹¹. A single road traffic crash affects drivers, other vehicle occupants, and witnesses, as well as their family members, work colleagues, and friends.

¹ World Health Organization (2004)

² World Health Organization (2004)

³ Australian Bureau of Statistics (2011a)

⁴ Australian Transport Council (2011)

⁵ Office of Road Safety (2009)

⁶ Marchant, Hill, Caccianiga, and Gant (2008)

⁷ Australian Transport Council (2011)

⁸ <http://www.ors.wa.gov.au/TopicsRoadSafety/Pages/SeriousInjuries.aspx>

⁹ Accessed 29th September 2011 from <http://www.ors.wa.gov.au/Statistics.aspx>

¹⁰ Hayward (1998)

¹¹ World Health Organization (2004)

Road traffic crashes are unexpected, sudden, and violent, and the likelihood of injury and death is significant. Furthermore, as crashes are a relatively common cause of death and injury, there is the opportunity of retraumatisation¹². These issues have the potential to complicate further the experiences of people who have been injured or lost a loved one in a crash, or witnessed such a crash. The psychosocial ramifications of road traffic crashes are different for the five affected groups:

1. People bereaved by road traffic crash fatalities;
2. People injured in road traffic crashes;
3. Families, friends, and unpaid carers of people injured in road traffic crashes;
4. Witness of, and first responders to, road traffic crashes; and
5. Offenders/people who allegedly cause the crash.

People bereaved by road traffic crash fatalities

Certain circumstances of death, such as sudden death, violent death, unanticipated death, preventable death, close relationship to the deceased, and the young age of the deceased, are major risk factors associated with 'complicated' grief outcomes. All of these risk factors are common in crash fatalities^{13,14}. Published studies focussing on bereavement through road traffic crash deaths reveal long-term consequences including intense grief, loss of meaning, psychological distress, anger, depression, guilt, and trauma.

One study investigated the outcome of 40 parents bereaved by the deaths of their adult children in crashes. Two years after the deaths, 30% of parents experienced depression, reported loneliness and guilt, bore a significant increase in the number of health complaints, and significant decreases in satisfaction with work, leisure, and life in general¹⁵. Another survey demonstrated that parents bereaved through the deaths of their children in traffic 'accidents' an average of four years previously showed high levels of psychiatric distress, 'traumatic' grief, anxiety, depression, insomnia, somatic symptoms, and social dysfunction¹⁶. A further study reported that 62% of individuals bereaved by drink-driving crash met criteria for Post-Traumatic Stress Disorder (PTSD) at just over two years following the crash¹⁷. Other studies of the long-term outcomes of losing a spouse or child in a crash indicate that the bereaved participants experienced more depression, more psychiatric symptoms, greater mortality, and less future orientation than do matched controls from a non-bereaved community sample¹⁸. There is also evidence of increased divorce rates of parents bereaved through traffic crashes when compared to matched controls¹⁹. Many of the bereaved experienced guilt and pain when thinking about their loved one, and experienced some distorted thinking believing that the death in a crash was not real²⁰.

¹² Keir (2000)

¹³ World Health Organization (2004)

¹⁴ Breen (2007)

¹⁵ Shanfield and Swain (1984)

¹⁶ Spooren, Henderick, and Jannes (2000-2001)

¹⁷ Sprang (1997)

¹⁸ Lehman, Wortman, and Williams (1987)

¹⁹ Lehman, Lang, Wortman, and Sorenson (1989)

²⁰ Lehman et al. (1987)

Another study investigated the prevalence of PTSD in a non-random sample of 57 people (48 women, 9 men) bereaved through crash fatalities²¹. The average time since bereavement was 4.5 years. The data revealed that two-thirds were experiencing symptoms of PTSD. The majority were experiencing anxiety symptoms (panic attacks and phobia), depression, suicidal ideation, guilt, anger, resentment, loss of drive, and decreases in both enjoyment in life and future orientation. The majority also experienced significant difficulties in their finances, relationships, social lives, status, and employment. The changes in relationships and social lives were significantly correlated with levels of depression and anxiety. The participants also reported life style changes, including poor nutrition, reduced exercise, alcohol use, and poor sleeping habits. Of all the lifestyle factors assessed, the change in their social lives was the factor most highly correlated with PTSD symptoms. Further, the majority of the participants expressed dissatisfaction with courts, solicitors, prosecution, coroner, insurance claims, ambulance, psychiatrists, and police. In addition, many were dissatisfied with the support received from the hospital, their church, general practitioners, mortuary, and counsellors, and this lack of support exacerbated the grief experience. A more representative sample of bereaved parents (the majority bereaved through traffic crashes) demonstrated that, five years after the death of a child, PTSD prevalence for mothers was nearly three times that in the general population; after five years, the prevalence of PTSD in fathers was twice that in the general population²².

The effects on the family resulting from losing a significant loved one in a crash are considerable and damaging. Common outcomes include withdrawal from relationships, communication breakdown, substance use, lack of direction in school and work, and isolation from friends. One study indicated that 90% of people bereaved through crashes reported significant and permanent reduction in their quality of life, and approximately half stated they had suffered an enduring decline in standard of living²³. A follow up survey of almost 700 families throughout Europe demonstrated that, following a crash fatality, 49% moved house, 11% experienced separation or divorce, and 91% reported an inability to take pleasure in life. Further, 60% of those who changed jobs did so because of their change in circumstances and 65% of those that lost their job reported doing so for psychological reasons²⁴.

In another study, people bereaved through crashes were surveyed to determine what helped and did not help them in the time (up to four years) after bereavement²⁵. Supportive behaviours include friends being 'there', visiting, and calling regularly; being understanding and emotionally supportive; providing instrumental aid such as helping with cooking, cleaning and child care and greeting visitors; listening without giving advice; assisting with funeral and other arrangements; and talking about the loved one. Unhelpful behaviours to the bereaved included a lack of empathy/understanding from friends and professionals; invasion of privacy; giving suggestions on how and when to grieve and stop grieving; presence of too many people 'helping'; friends withdrawing/being unavailable, and avoidance of talking about the loved one.

²¹ Tehrani (2004)

²² Murphy, Johnson, Chung, and Beaton (2003)

²³ Federation of European Road Traffic Victims (1993)

²⁴ Federation of European Road Traffic Victims (1995)

²⁵ Lord (2000)

A comprehensive study of people bereaved by road traffic crashes in WA highlighted the potential for family conflict, declines in social support, doubts and frustrations regarding lengthy legal, insurance, and health contests²⁶. The participants' grief experiences challenged the dominant discourse of grief as a short-term, stage/phase/task-based, finite, and meaningful phenomenon that culminates in the detachment from the deceased loved one. Instead, they described their grief as unique, long-lasting, and characterised by an oscillation of emotions, whereby meaning and/or positives were not found. Further, they experienced significant and permanent changes in their social support networks²⁷ difficulties in negotiating the legal and coronial processes²⁸, and highlighted the importance of peer support in order to ameliorate their feelings of loneliness, isolation, and dislocation²⁹.

It is important to note here that conventional wisdom has suggested that bereavement through suicide yields the most significant impairments and outcomes. However, more recent comparative research demonstrates that there are few differences. For example, one study compared mental health outcomes following spousal bereavement via suicide, traffic crash, and terminal illness³⁰. The researchers found no overall significant difference between groups; however, they reported that the spouses bereaved through road traffic crashes tended to have higher scores for shame, self-blame, sadness, guilt, and self-harm ideation than did the other groups. Similarly, a study of parents bereaved by the violent deaths of their children revealed almost little overall significant differences between those bereaved through traffic crash, suicide, and homicide^{31,32}.

People injured in road traffic crashes

Road traffic crash fatalities are significantly outnumbered by the number of people who suffer permanent impairment and disability following injury³³. Of all types of injuries that may result in road traffic crashes, whiplash has attracted the most attention. Unfortunately, people reporting whiplash injuries are often (and erroneously) thought to be neurotic malingerers motivated by financial compensation³⁴. Other injuries include spinal cord injury, brain injury (short-term and long-term), broken and fractured bones (especially skull, vertebrae, rib, sternum, facial bones, clavicle, scapula, humerus, ulna, radius, hand, pelvis, femur, patella, tibia, fibula, ankle, and foot), dislocations, sprains, internal injuries, open wounds, burns, contusions, and lacerations³⁵. Permanent disability occurs as a result of paraplegia, tetraplegia, and quadriplegia, loss of eyesight, some brain injuries, and disfigurement. These issues can lead to social and psychological effects such as concerns for appearance, body images issues, discrimination, and social isolation^{36,37}. Less serious but more common injuries may result in chronic pain and limitations in activity.

²⁶ Breen (2007)

²⁷ Breen and O'Connor (2011)

²⁸ Breen (2007)

²⁹ Breen and O'Connor (2010)

³⁰ Grad and Zavasnik (1999)

³¹ Murphy Johnson, Wu, Fan, and Lohan (2003)

³² Murphy et al. (2003)

³³ WHO (2004)

³⁴ Mayou (1997)

³⁵ World Health Organization (2004)

³⁶ Charlton, Rumsey, Partridge, Barlow, and Saul (2003)

³⁷ Rusch (1998)

Over one-quarter (28%) of Australians who are seriously injured in road traffic crashes sustain life-threatening injuries³⁸. One study of 157 patients five years after injury reported that the most severe disabilities resulted from brain and spinal cord injuries and that the effects persisted over the long-term³⁹. It is estimated that 15% of all Australians hospitalised due to a road crash will sustain a disabling injury⁴⁰. Of these, 27% (or 1270 people) will have a severe or profound limitation with the remainder possessing some degree of moderate to minor core disability that may restrict employment or schooling.

In addition to physical injuries, post-trauma reactions, including intrusive thoughts, chronic and disabling anxiety, and travel phobia, are commonly associated with being injured by, or even being involved in, a road traffic crash⁴¹, as are trauma-related nightmares, insomnia, and sleep disturbances⁴², and reductions in quality of life⁴³. When frequency of traumatic events is combined with resulting severity of trauma, road traffic crashes are the most significant cause of PTSD⁴⁴. One study revealed that almost one-fifth of all people hospitalised after a road traffic crash were suffering acute stress, disturbed mood, and horrifying memories of the events of the crash and one-tenth met the criteria for PTSD⁴⁵. Another study investigated the prevalence of PTSD in a non-random sample of 46 people (33 women, 13 men) bereaved through crash fatalities⁴⁶. The average time since injury was 5.5 years. The data revealed that four-fifths met criteria for PTSD. A comprehensive review of almost five decades of international studies demonstrated that between 15 to 45% of survivors of serious road traffic crashes will develop PTSD, either acutely or within one year of the crash⁴⁷. Furthermore, they are at an increased risk of comorbid disorders of mood, anxiety, and alcohol and other drug use⁴⁸. ASD is a more recent diagnostic category⁴⁹ and therefore there is a much smaller body of research on ASD following road traffic crashes⁵⁰. Importantly, not everyone who is involved in a road traffic crash will develop traumatic reactions; however, psychological/psychiatric complications are more common in people with pre-existing mental, social and medical problems⁵¹ and the development of PTSD is more likely in women survivors of road traffic crashes⁵².

A small study of 26 people who had been injured in road traffic crashes demonstrated that all reported a degree of disability at the time of discharge from hospital, including pain, restricted movement, severe headaches, breathing difficulties, and memory loss⁵³. Two in five rated their disability as 'severe' at the time of discharge. Three-quarters required

³⁸ Australian Institute of Health and Welfare (2011)

³⁹ Dunn, Patterson, and Boot (2000)

⁴⁰ Bureau of Infrastructure, Transport and Regional Economics (2009)

⁴¹ Mitchell (1997)

⁴² Kobayaski, Sledjeski, Spoonster, Fallon, and Delahanty (2008)

⁴³ Lucke, Coccia, Goode, and Lucke (2004)

⁴⁴ Norris (1992)

⁴⁵ Mayou, Bryant, and Duthie (1993)

⁴⁶ Tehrani (2004)

⁴⁷ Blanchard and Hickling (2004)

⁴⁸ Blanchard and Hickling (2004)

⁴⁹ American Psychiatric Association (2000)

⁵⁰ Blanchard and Hickling (2004)

⁵¹ Mayou Bryant, Duthie, and Talbot (1995)

⁵² Blanchard and Hickling (2004)

⁵³ Oxley and Fildes (1993)

assistance and support following discharge, including physiotherapy, orthodontics, occupational therapy, neurology, psychology, psychiatry, and social work, as well as community services to assist with meals, transport, cleaning, washing, and home maintenance. Most of the respondents indicated they had incurred out-of-pocket expenses. Other, less quantifiable, consequences they reported included a reduction in confidence, memory, and concentration abilities (affecting engagement in complex tasks such as driving as well as the ability to enjoy novels and films); increases in anxiety, depression, irritability, and frustration; diminished participation in leisure and social activities; and limitations in career ambitions.

Families, friends, and unpaid carers of people injured in road traffic crashes

Under the Carers Recognition Act 2004, carers are defined as family or friends who provide unpaid and ongoing assistance to someone with a disability, chronic illness, mental illness or who is frail. Estimates of the number of carers in WA vary from approximately 250,000⁵⁴ to just over 300,000⁵⁵; these figures equate to about one in every eight people occupying a caring role. Carers often do not think of themselves as a carer, but rather just as a parent, partner, son or daughter caring for a family member, or for a friend. However, the caring role they provide is often essential to the wellbeing and/or recovery of the person they support. If the care provided by family and friend carers had to be replaced by paid staff, the cost in WA alone would be over \$4 billion annually⁵⁶. Unless the carer is supported in their caring role, it can take a toll on the physical, psychological, and financial wellbeing of the carer and their family⁵⁷. Carers have the lowest levels of wellbeing of any social cohort in Australia⁵⁸. For this reason, the Commonwealth Government and many states, including WA, have introduced legislation that requires health and disability service providers to recognise and include carers in the recovery planning process. This is to ensure that carers are given the opportunity to provide relevant information about the person being cared for so that services have a more complete picture of service needs and to ensure that carers are assessed in their own right and referred to relevant agencies for support services, such as education and training, counselling, and respite.

The physical, psychological, and behavioural consequences outlined above also affect the injured person's family members and friends. Families might be affected by a significant decrease in income, and an increase in bills, in addition to physical and emotional suffering⁵⁹. The financial costs following injury may be considerable and include medical/treatment bills, transport costs, and loss of wages due to the need to take time from paid employment or the inability to resume paid employment. Additionally, people who are injured may rely on an unpaid carer (or carers), and this may range from being a temporary arrangement and for specific needs to ongoing provision of core activities of daily living. A survey of Australian family carers providing care following a family member's brain injury demonstrated that the carework interfered with the carers' ability to find paid employment⁶⁰.

⁵⁴ Australian Bureau of Statistics (2011b)

⁵⁵ Edwards Gray, Baxter, and Hunter (2007)

⁵⁶ Access Economics (2010)

⁵⁷ Brain Injury Australia (2011)

⁵⁸ Cummins, Hughes, Tomy, Gibson, Woerner, and Lai (2007)

⁵⁹ Lord (2010)

⁶⁰ Chan (2007)

Much of the research on carer's needs following road traffic crashes is focussed on acquired brain injuries and spinal cord injuries. This research demonstrates that entire family systems may experience psychological distress⁶¹ and that these effects persist over the long-term. For instance, one study of families two and five years following traumatic brain injury showed that over one-third of families showed unhealthy functioning and many carers were affected by anxiety and depression⁶². A survey of 52 primary carers, an average of six years following their family member's traumatic brain injury, indicated that carers who are distressed by their family member's ongoing needs are more likely to experience burden and depression⁶³. Another study of 23 carers of family members with traumatic brain injury found that, one year after the injury, carers were considerably strained and their strain was not ameliorated by positive coping strategies⁶⁴. Finally, a study of 97 parents whose children had traumatic brain injuries demonstrated that these parents experienced greater stress and financial problems and reduced psychological health than compared to a community sample⁶⁵. Carers do not have a finite loss; their grief is ongoing yet unacknowledged by friends, family and society in general. Post-traumatic symptoms are often self-managed (whether through sleep medication, anti-anxiety medication or maladaptive behaviours such as alcohol or other drug use) so that the carer can continue their caring role. Carers often report difficulties in accessing the information they require in order to provide a good quality of care for the person they support⁶⁶. In some cases, a person who has experienced a serious injury may be dependent on their carer to seek information about services, including future planning. Additionally, carers have support needs of their own, for which they need appropriate referrals as many carers do not recognise their own needs.

Formal financial support is available from the Commonwealth government through Carer Allowance, Carer Payment, and other types of assistance such as concession cards, rent assistance, and pharmaceutical subsidies. The eligibility criteria for Carer Allowance and Carer Payment are strict – the majority of carers do not receive them – and the payments fail to recognise their considerable effort involved in care. For example, when combined, the full Carer Payment and Carer Allowance is still \$200 less per week than the Australian minimum wage⁶⁷. Furthermore, despite the limited financial support, paid work is often incompatible with the circumstances of unpaid carers, and compared to the general population, carers are much more likely to experience economic, social, and health disadvantages as a result of their engagement in the carer role⁶⁸. Indeed, when one member of family is impaired, the entire family system may become 'disabled' by the ongoing effects of financial strain, gaps in service delivery, and social stigma⁶⁹.

Witnesses of and first responders to road traffic crashes

Helpers at the scene of a road traffic crash, as well as witnesses, often experience considerable distress. Emergency service personnel are particularly vulnerable due their

⁶¹ Perlesz, Kinsella, and Crowe (2000)

⁶² Ponsford and Schönberger (2010)

⁶³ Knight, Devereux, and Godfrey (1998)

⁶⁴ Mitchley, Gray, and Pentland (1996)

⁶⁵ Hawley, Ward, Magnay, and Long (2003)

⁶⁶ Email from Stephanie Fewster, Carers WA, to Lauren Breen, 26th September 2011

⁶⁷ Hughes (2007)

⁶⁸ Australian Bureau of Statistics (2008)

⁶⁹ Breen (2009)

repeated exposure to traumatic events (attending fatal crashes, issuing death notifications, being present at the family's identification of the body, and so on), and are at-risk of experiencing intrusive thoughts, traumatic dreams, and feelings of anger, fear, and helplessness⁷⁰. Sleep, appetite, and the ability to work and drive might also be affected⁷¹. Police (and emergency service personnel) can be greatly and adversely affected by attending and investigating fatal crashes^{72,73}. On the other hand, others have argued that distress is more likely to occur in witnesses not employed by emergency services as they do not have access to the professional supervision and debriefing processes that emergency personnel have in the course of their work – they have been described as “hidden casualties”⁷⁴.

Offenders/People who allegedly cause the crash and their families

Drivers in a crash (whether or not they are legally liable) tend to be affected by guilt at causing injury and/or death. They often must wait months for the outcome of a police investigation and even longer if the case goes to court⁷⁵. Sometimes, the person who allegedly caused the crash also dies; in such situations, the grief of the drivers' family members is coloured by feelings of anger towards the driver, and shame and guilt that a family member has caused the death or injury of another person, and these feelings vacillate with the desire to protect his or her memory and reputation. These complex feelings and thoughts are further complicated by media coverage, which may be intense, anger towards the driver and perhaps his or her family, and social stigma and isolation⁷⁶.

Economic ramifications

Globally, the direct economic cost of road traffic crashes has been estimated at US\$518 billion, therefore representing a significant burden worldwide⁷⁷. The estimated costs of Australian crashes reached almost \$15 billion in 1996⁷⁸ and \$17.85 billion in 2006⁷⁹. The current estimate is that road traffic crashes cost Australia \$27 billion⁸⁰. These total consisted of human costs, vehicle costs, and general costs. Human costs are those associated with ambulances, hospitals, rehabilitation, long-term care, workplace and household labour, quality of life, legal and coronial processes, correctional services, and funerals. Vehicle costs consist of repairs, towing, and vehicle unavailability. General costs include travel delays and the administration of insurance. The average fatal crash costs \$2.67 million⁸¹. It is likely that the average cost is under-estimated once loss of lifetime earnings is included.

These financial costs highlight the economic burden of crashes on the Australian economy yet have been criticised as ‘deficient’ and ‘rough’⁸² because they are based on selective road

⁷⁰ Hetherington, Munro, and Mitchell (1997)

⁷¹ Downes (2010)

⁷² Cowan (2005a)

⁷³ Cowan (2005b)

⁷⁴ Jeavons (1997, p. 208)

⁷⁵ Downes (2010)

⁷⁶ Bateman (2010)

⁷⁷ World Health Organization (2004)

⁷⁸ Bureau of Transport Economics (2000)

⁷⁹ Bureau of Infrastructure, Transport and Regional Economics (2009)

⁸⁰ Australian Transport Council (2011)

⁸¹ Bureau of Infrastructure, Transport and Regional Economics (2009)

⁸² Giles (2003a)

crash data collection methodology^{83, 84} and use the non-preferred method of cost calculation⁸⁵. Instead, the cost of Australian crashes in 1996 is likely to be greater than \$344 billion⁸⁶ and the consequences of accepting this estimate are twofold – crash prevention would be a greater priority than its current status, and measures to reduce crashes would no longer be abandoned based on cost-benefit analyses.

Conclusion

Psychosocial consequences may include serious physical injuries and temporary or permanent disability, intense grief, post-trauma reactions, psychiatric disorders, social isolation and stigma, decreases in quality of life, restricted opportunities for leisure, carer burden, and considerable financial costs. Estimates show that road traffic crashes and their consequences cost Australia between \$27 billion and \$344 billion per year. Despite crashes being a major cause of death and injury worldwide, there are few studies explicating the psychosocial experience of grief following crashes and even fewer on the experiences of others affected by road traffic crashes. In fact, the World Health Organization describes road crashes and their consequences as “neglected”⁸⁷, “notoriously hidden”⁸⁸, and “part of the almost unnoticed background”⁸⁹. The “steady drip”⁹⁰ of crashes and their consequences means that other causes of death warrant significantly more media attention and are considered to be legitimately traumatic. It is clear from the above analysis that there are significant psychosocial and economic ramifications of road traffic crashes for drivers, passengers, family, friends, colleagues, witnesses, emergency service workers, and even entire communities.

⁸³ Giles (2001)

⁸⁴ Giles (2003b)

⁸⁵ Giles (2003a)

⁸⁶ Giles (2003a)

⁸⁷ WHO (2004, p. 3)

⁸⁸ Clark (2004, p. 11)

⁸⁹ Job (1999, p. 38)

⁹⁰ Browning (2002, p. 1165)

4.0 SERVICES AND SUPPORTS FOR PEOPLE AFFECTED BY ROAD TRAFFIC CRASHES IN WESTERN AUSTRALIA

Over a period of at least eight years, the Department of Health (WA) has continued to receive requests for the establishment of a state-wide road trauma support service. Despite the psychosocial ramifications of road traffic crashes (Section 3), there is no such service in WA. In this section, the current services and supports for people affected by road crashes in WA are described.

Coronial Counselling Service

The Coroner investigates all deaths that are not natural or where causes are unknown in order to establish the identity of the deceased and the manner and cause of death. A component of the state's Department of the Attorney General, The Coronial Counselling Service commenced in January 1995, is free to access, and consists of three counsellors (either social workers or clinical psychologists) and six volunteer staff members who act as companions during coronial inquests. The Coronial Counselling Service is situated within the Office of the Coroner in the Perth central business district. The counsellors are available everyday between 7am and 6pm and are on-call outside of working hours and at weekends⁹¹. The counsellors provide an interface between families and the coronial systems and guide and assist families through the coronial processes. A counsellor might make one home visit (to people in the metropolitan area), but they usually meet with the immediately family members of deceased crash victims either at the office or talk over the telephone. The counsellors provide information about the coronial investigation process (e.g., post-mortem examinations, coronial inquires and inquests, medical terminology, organ retention, viewing of the body and police files)⁹², counselling during the process, and arrange referral to other community agencies or professional counsellors. For people outside of Perth, the consultations occur via telephone. The counsellors had over 6,000 contacts with families last year⁹³. Existing resources are stretched and are recognised as inadequate to cater for community needs.

The bereaved next-of-kin are informed about the Coroner, the coronial process (including the post-mortem examination and organ donation), and the Coronial Counselling Service via a brochure⁹⁴ issued by the police, on behalf of the Office of the State Coroner, either at the notification of the death or the identification of the body. It is assumed that the bereaved next-of-kin will keep the pamphlet for future reference. However, a study of people bereaved by road traffic crashes in WA⁹⁵ reported that many described the name of the service as a barrier to them accessing the support because of its relationship to unnatural death and/or the ideas that its users must have psychological problems that require counselling; some thought that the Coronial Counselling Service provides a single counselling session only; and some report that they had not heard of the Coronial Counselling Service⁹⁶.

⁹¹ http://www.coronerscourt.wa.gov.au/H/how_we_can_be_contacted.aspx?uid=1040-8621-3841-2469

⁹² http://www.coronerscourt.wa.gov.au/W/who_are_we.aspx?uid=4989-5893-3330-8287

⁹³ Email from Gary Cooper, Office of the State Coroner, to Lauren Breen, 5th September 2011

⁹⁴ http://www.coronerscourt.wa.gov.au/files/When_A_Person_Dies_Suddenly.pdf

⁹⁵ Breen (2007)

⁹⁶ The issue of not knowing about the Coronial Counselling Service was also identified in a study of Western Australians bereaved through the suicide of a family member (Hillman, Green, & Silburn, 1999).

Furthermore, some of this study's participants reported that reading and understanding the pamphlet is difficult given their state of mind at the time, and the extent of shock, numbness, and cognitive changes a person is likely to experience when bereaved suddenly.

Insurance Commission of WA

The Insurance Commission of WA is The Insurance Commission is the sole Compulsory Third Party Insurer for motor vehicle personal injuries in Western Australia⁹⁷. It tends to be described as difficult to negotiate and not user-friendly as injured claimants are required to 'relive' their trauma in order to be assessed, which is a long process and financially stressful. Providing that negligence of someone other than the deceased can be proved, the Insurance Commission of WA covers the repair or replacement costs of motor vehicles damaged in crashes. It also reimburses families for the cost of a funeral when someone else is at fault for causing the fatal crash. However, the reimbursement of funeral costs is not always straightforward – eligible people might not be aware of the entitlement and the process of making the claim is difficult, because of the need to prove negligence on the part of an offender⁹⁸. The fault-based nature of the system creates a potentially adversarial environment that contributes to the difficulties of dealing with a loved one's death in a crash. In fact, fault-based compensation systems (like that in WA) have been described as "inefficient, costly and something of a lottery"⁹⁹. The Insurance Commission of WA does not provide counselling or other supports.

Victim Support Service

Launched in 1992, The Victim Support Service is a component of the Department of the Attorney General and provides information and support to victims of crime. Services include explanations of criminal and judicial systems, court preparation, court companionship, assisting in the preparation of victim impact statements, and short-term counselling¹⁰⁰. The Victim Support Service book, *What do I do now?*,¹⁰¹ has been available primarily from the Victim Support Service since 2004 and is available online¹⁰². Chiefly aimed at assisting families where a loved one is killed violently (e.g., homicide), it includes information of a number of topics including grief, funerals, the police investigation, the prosecution process, support services, and compensation and insurance claims.

Staff members are available throughout WA, and in particular, in at least one town/city in each of the nine non-metropolitan regions, ranging from Albany in the south to Kununurra in the north. In addition, trained volunteers provide assistance to bereaved family members during the legal trial. However, assistance from the Victim Support Service is not provided until charges are laid or are likely to be laid. The time lag is unique to crash fatalities and injuries, because of the potential for delay in determining if an offence has been committed¹⁰³. However, timeliness in the provision of support is crucial and it is significantly more difficult to provide such assistance when a delay has occurred, as is often the case for road traffic crashes.

⁹⁷ <http://www.icwa.wa.gov.au/>

⁹⁸ Breen (2007)

⁹⁹ Lloyd-Bostock (1997, p. 135)

¹⁰⁰ http://www.victimsofcrime.wa.gov.au/V/victim_support_services.aspx?uid=7806-3612-3048-1357

¹⁰¹ Victim Support Service (n.d.)

¹⁰² <http://www.courts.dotag.wa.gov.au/files/WhatNow.pdf>

¹⁰³ Breen (2007)

Lifeline

Lifeline provides a 24-hour telephone support and crisis counselling service. The service is available state-wide for the cost of a local telephone call. It previously offered a Road Trauma Counselling Service, which was launched on the 7th December 2001 with an aim to support people who witnessed or were bereaved or injured in a crash. The catalyst for the development of the service was a double fatality on the South-West Highway in the Shire of Serpentine-Jarrahdale¹⁰⁴, approximately 45 kilometres southeast of Perth. A local resident, who assisted at the scene of the crash until emergency services arrived, later experienced severe anxiety related to witnessing the crash and resulting trauma. As a result, Roadwise¹⁰⁵ decided to develop a state-wide support service aimed specifically at witnesses of crashes. The steering committee included a number of relevant stakeholders, including Roadwise, Lifeline, Shire of Serpentine-Jarrahdale, Department of Health, Coronial Counselling Service, WA Police, emergency services, the Insurance Commission of WA, and people bereaved through crashes¹⁰⁶.

The committee developed a card that could be issued by police and emergency services to witnesses at the scene of crashes, as well as to family members, and also could be distributed via a number of community services (police stations, general practitioners, emergency services, and so on)¹⁰⁷. To develop the service, Roadwise contributed \$5000, of which \$3000 went to Lifeline for training of their telephone counsellors¹⁰⁸ in areas specific to witnessing trauma and experiencing grief resulting from sudden and violent events. Training covers suicide, grief and loss, sexual assault, child abuse, trauma, some psychological/psychiatric disorders, and counselling skills. The limited funding meant that the training of the telephone counsellors was not as thorough as it could have been¹⁰⁹. In addition to the telephone service, Lifeline developed a state-wide referral service of counsellors who provide their first consultation for free or for a reduced fee. The remainder of the funding was used to print and disseminate the cards across the state. The dissemination process was slow and focussed on supporting witnesses of crashes rather than all people affected by road trauma.

The service averaged four to five phone calls per month^{110,111}. The small number of calls was attributed to the difficulty potential users of the service might have in making the connection between being in a crash, witnessing a crash, or losing someone in a crash, and the development of subsequent problems. In addition, any problems in coping are often likely to surface after a number of weeks or even months after the crash, suggesting that the service needs to be advertised more broadly than just at the time of the crash. The service was able to provide very limited support to people bereaved through crashes for a number of reasons¹¹². First, approximately 20% of all calls were answered by a telephone counsellor,

¹⁰⁴ Parker, Parsons, and Pettet (2002)

¹⁰⁵ Roadwise is the local government road safety strategy. It receives approximately 1.2 million dollars a year from the Road Safety Council of WA.

¹⁰⁶ Parker et al. (2002)

¹⁰⁷ Parker et al. (2002)

¹⁰⁸ Lifeline consists of approximately five paid counsellors and 200 volunteer telephone counsellors.

¹⁰⁹ Breen (2007)

¹¹⁰ Breen (2007)

¹¹¹ Parker et al. (2002)

¹¹² Breen (2007)

rendering the majority of calls unanswered. Second, the telephone counsellors possess limited training and skills in relation to road trauma. Third, the service remained largely unpublicised, and those affected by crashes were likely to remain unsupported by the service. Fourth, the service was under-funded, given its brief as a state-wide initiative. Fifth, the service was potentially not the most appropriate support service for people bereaved through crashes, as people who are affected by crashes are not likely to frame their resulting issues as 'road trauma' or as resulting from a crash. Finally, other services refused to refer clients to the telephone line because of quality concerns. In 2005, Lifeline attempted to access additional funding from the Road Safety Council in order to develop the service. The funding submission was unsuccessful as the Government of WA's road safety strategic plan does not provide for post-crash supports¹¹³.

WA Police

Police officers attending fatal crashes do not readily attend to the psychosocial needs of bereaved family members for a number of reasons, including being consumed with other tasks such as collecting information and evidence, detaching from the trauma so as to protect themselves, and a lack of training that would adequately enable them to attend to the psychosocial consequences of crashes¹¹⁴. A part-time Investigating Officer fulfilled the duties of Family Liaison Officer in Major Crash from 2008. It was recognised that the role required full-time hours and the position became full-time in 2009. The Family Liaison Officer notified the family of the circumstances of the death, established and maintained a rapport with the family and/or friends of the victim, assisted in the arrangement of visual identification of the victim, facilitated the flow of information between the investigation team and the family, prepared the family for media enquiries, and introduced the family to the Victim Support Service and other supports¹¹⁵. This Officer provided follow-up support and information for next-of-kin and families during police investigation of crashes. Demand for support exceeded the resourcing of the position – the Officer estimated being able to make up to 50 referrals a month to a road trauma support service, should it exist¹¹⁶. In 2010 the decision was made to absorb the role into the duties of all Investigating Officers rather than resource the role as a standalone position¹¹⁷. However, despite no longer existing, the role of Family Liaison Officer remains in the book, *What do I do now?*, produced by the Victim Support Service¹¹⁸.

Road trauma memorial site

Roadwise, the WA Police, and the Town of Victoria Park initiated the development of a memorial in remembrance of those bereaved through crashes. The memorial was launched 13th December 2002, with speeches by the Assistant Police Commissioner, the Chair of the Road Safety Council, the Police Chaplain, and the Mayor of the Town of Victoria Park. During their speeches, the Assistant Commissioner used the forum to promote police road safety campaigns and the Mayor criticised the use of speed cameras in the local area. Consequently, their focus was not on the psychosocial consequences of crash fatalities.

¹¹³ Office of Road Safety (2009)

¹¹⁴ Hetherington et al. (1997)

¹¹⁵ Victim Support Service (n.d)

¹¹⁶ Email from Corinne Moulé, WA Police, to Glenda Maloney, 26th October 2009

¹¹⁷ Telephone interview with Acting Inspector Gary Nicholau, Major Crash, WA Police, 17th August 2011

¹¹⁸ Victim Support Service (n.d.)

Some people who attended the launch questioned the motives behind it and described it as “absolutely asinine” and a “publicity stunt”¹¹⁹. The memorial is located in a small, grassed area between two very busy carriageways in the suburb of Victoria Park. The area is noisy, open, and surrounded by traffic, does not encourage quiet reflection, and therefore is not an appropriate location for a memorial.

Hospital and mental health services

Hospitals (public and private) can link people to emergency and inpatient psychiatric services. The Department of Health’s Mental Health Emergency Response Line (formerly the Psychiatric Emergency Team) provides psychiatric emergency assessment and advice¹²⁰. Social Workers at State hospitals also have a role in supporting families and victims of vehicle crash events but again services are stretched and are not available in the longer term. The Department of Health also offers Child and Adolescent Mental Health Services, Community Mental Health Clinics and Consultancy Services, Inpatient and other mental health services, and Country Mental Health Services¹²¹.

Health Direct

Health Direct is a free, 24-hour telephone health information service staffed by Registered Nurses and available in most Australian states¹²². Callers may be directed to their GP who can then refer patients to counselling/psychology/psychiatry services.

Counselling/psychology/psychiatry services

General practitioners, psychiatrists, and paediatricians may refer their patients to Medicare-subsidised allied mental health service providers (i.e., psychologists, social workers, and occupational therapists). The recent Federal budget¹²³ revealed funding cuts to the Better Access initiative, involving a cap on the number of sessions per patient provided by allied health providers and a cut in the rebate for GPs preparing Mental Health Treatment Plans. From 1 November 2011, patients will be able to access up to six Medicare-subsidised allied mental health services per calendar year, with an additional four available to patients who require additional assistance¹²⁴. According to the Government, the changes to Better Access aim to provide better targeting of Better Access services to patients with mild to moderate mental illness, while patients with more severe mental illness will be provided more appropriate treatment under other programs such as the Access to Allied Psychological Services (ATAPS) program. If the allied mental health professional uses bulk-billing, there is no cost to the client; however, in the majority of instances, clients generally are required to pay a gap of \$33 to \$39 per session¹²⁵ but it may be considerably more. People can also access private practitioners and services via other methods (e.g., perusal through the Yellow Pages for counsellors and psychologists, the Australian Psychological Society’s Find a Psychologist service) for a fee, typically significantly greater than the Better Access fee. Private sessions can be hundreds of dollars each. For instance, the recommended fee for a

¹¹⁹ Breen (2007)

¹²⁰ http://www.health.wa.gov.au/services/detail.cfm?Unit_ID=172

¹²¹ http://www.health.wa.gov.au/services/category.cfm?Topic_ID=5

¹²² <http://www.healthdirect.org.au/>

¹²³ <http://www.budget.gov.au/>

¹²⁴ <http://www.medicareaustralia.gov.au/provider/budget-2011/NMHR-better-access-initiative.jsp>

¹²⁵ Pirkis, Harris, Hall, and Ftanou (2011)

one-hour session with a psychologist is \$260¹²⁶. Hence associated costs for ongoing professional therapeutic interventions can be considerable.

Employee assistance programmes

Many employers contract employee support and assistance organisations to provide counselling support for their employees, and in many cases, for family members of the employees. Typically, employees may access up to six counselling sessions per year free of charge. These programmes are usually only available through large employer organisations, the counselling sessions are limited, and counsellors are unlikely to be trained in grief and trauma therapeutic interventions.

Chaplaincy, religious and spiritual congregations, and beliefs

Chaplaincy services are available through churches, hospitals, schools and through WA Police and St John Ambulance, with the latter two having a trauma support role. Religious and spiritual beliefs are sources of resilience for many, but not all, people affected by road trauma. One study of people bereaved in drunk driving crashes found that, five years following the crash, 50% reported their faith was strengthened, 35% reported it was the same as before the crash, 12% said their faith had weakened, and 3% reported no longer having faith¹²⁷. However, it is necessary to recognise that a faith community may not be supportive in the face of road trauma¹²⁸.

Mutual-help and support groups

ConnectGroups is the peak body for self-help and support groups in WA. It is important to note that there is no specialised road trauma support group in WA¹²⁹. An attempt to set up a metropolitan road trauma support group was initiated by a community member in partnership with ConnectGroups in 2009. Although the group was advertised through radio and fliers placed in some GP surgeries, the initiative was not successful due to lack of participation from the community, presumably because the support group wasn't 'housed' within an existing service, nor were existing services referring people to the group. ConnectGroups is able to link people affected by road trauma to existing groups within the mental health and bereavement arena – however those affected do not tend to find them appropriate to their situation.

There are several mutual-help groups in WA that can be accessed by people affected by road trauma. The most commonly accessed one would be The Compassionate Friends (TCF)¹³⁰. Formed in the United Kingdom in 1969¹³¹, TCF is a non-religious mutual support organisation for bereaved parents, assisting them to meet each other and share experiences in a sympathetic and compassionate environment. Support meetings, called Friendship Nights and Coffee Mornings, are each hosted once a month and held at their office in West Perth. Support from TCF tends to be characterised as empathic, accepting, and non-judgemental, as bereaved parents understand the daily challenges of living with the death of a child of

¹²⁶ www.psychology.org.au

¹²⁷ Mercer (1995)

¹²⁸ Lord (2010)

¹²⁹ Email from Antonella Segre, Executive Officer of ConnectGroups, to Lauren Breen, 20th June 2011

¹³⁰ Others include SIDS and Kids, Solace, Angelhands, and GROW

¹³¹ Lawley (2006)

which those without the experience would not be aware¹³². Support from TCF often becomes more important over time when the understanding and compassion from within people's natural support networks (i.e., friends and family) diminishes, as TCF allows people to continue to talk about their loss^{133,134}.

The West Perth office has an extensive library of books and resources pertaining to grief and loss available free of charge to grieving parents. The office is staffed by bereaved parents who act as volunteers and is open most weekdays. TCF publishes pamphlets on particular aspects of grief and loss (e.g., *When your child dies*, *Caring for surviving children*, *How can I help when a child dies*, and *Suggestions for doctors and nurses*) as well as a quarterly newsletter (*Reflections*); bereaved parents are encouraged to contribute to the publications. Although the focus is on bereaved parents, TCF also attempts to support grieving grandparents, siblings, and other relatives^{135,136}. TCF facilitates the development of networks between parents grieving the loss of a child through similar means, such as asthma, AIDS, drug-related, neonatal, suicide, vehicle crashes, and deaths in custody, as well as groups such as Aboriginal children and young children (The Compassionate Friends, 2003). TCF is also represented in many regional areas throughout WA¹³⁷.

TCF has reduced rent office space in a building provided by the state government but receives no ongoing funding from any source and as such relies on self-funding. As a result, TCF provides *Reflections* free for the first year, but after a year a \$25 charge per year applies¹³⁸. However, many bereaved people do not access TCF, for four reasons¹³⁹. First, is the perception that TCF is for bereaved parents only; second, some bereaved people want to talk to others bereaved by the same cause of death; third, attending meetings can be difficult when having to drive to TCF and back home alone, at night, and while potentially distressed; and fourth, the courage required to attend the first meeting.

Formed in 2000, Australian Parents Against Road Trauma (APART) was a small advocacy group that advocated for legislative change¹⁴⁰ and did not provide counselling or meetings¹⁴¹; however, it is (erroneously) described as a "support group" in the Victim Support Service's book, *What do I do now?*¹⁴².

Carers groups and services

Carers WA is the peak body representing and supporting carers in WA and WA is recognised by both the State and Federal governments as the voice of family carers¹⁴³. It is a non-profit, community based organisation and registered charity dedicated to improving the lives of

¹³² Breen (2007)

¹³³ Breen and O'Connor (2010)

¹³⁴ Breen and O'Connor (2011)

¹³⁵ The Compassionate Friends (2003)

¹³⁶ The Compassionate Friends (n.d.)

¹³⁷ The Compassionate Friends (2003)

¹³⁸ The Compassionate Friends (2003)

¹³⁹ Breen (2007)

¹⁴⁰ http://www.victimsofcrime.wa.gov.au/S/support_groups.aspx?uid=6534-1045-2645-1300

¹⁴¹ <http://www.connectgroups.org.au/modules/directory/vieworg.php?id=2600>

¹⁴² Victim Support Service (n.d., p. 7)

¹⁴³ <http://www.carerswa.asn.au/about-carers-wa/>

family and friend carers living in Western Australia. Of the approximately 10,000 carers listed on the Carers WA database, 523 care recipients have an acquired brain injury (including from road trauma) and many others have a physical disability resulting from road trauma¹⁴⁴.

Carers WA works in active partnership with carers, persons with care and support needs, health professionals, service providers, government and the wider community to achieve an improved quality of life for carers. Carers WA offers family carers counselling (face-to-face, telephone and email), advice, education and training, social and peer support, a Young Carer program and the 'Prepare to Care' hospital program, which includes the dissemination of a resource pack for family carers. The pack provides information for family carers during and after hospitalisation and includes a glossary of important terms, tips, checklist for going home following discharge, useful contact numbers, a health and medication diary, a pen, and a lanyard with identification as a family carer.

Carers can access counselling via the state-wide telephone carer counselling line, face-to-face counselling in seven metropolitan and eight regional locations, and email counselling. Counselling is provided to carers of people with all types of injuries and disabilities resulting from road traffic crashes. Generally, the counselling focuses on building resilience to be able to continue caring; however, there is a strong emphasis on supporting carers to cope with ambiguous loss, disenfranchised grief and post-traumatic stress symptoms. It is common for carers to have symptoms of complicated grief and PTSD; however, due to their focus on the care recipients' needs, they are unlikely to be diagnosed with such disorders.

Journey Beyond Road Trauma

Journey Beyond Road Trauma is a website that allow registered users to create tributes, connect with people affected by road trauma, tell their story, and campaign for road safety¹⁴⁵. The site is not a counselling or support service; it does provide information and contact details of support services but none of the services listed on the site are specific to WA¹⁴⁶. The site was a finalist in the inaugural 3M-ACRS Diamond Australian Road Safety Awards and was commended as an initiative that stands out beyond traditional activities and delivers improved road safety¹⁴⁷.

Miscellaneous documents and brochures

Other, more detailed, brochures have existed in the past but are no longer in print¹⁴⁸. The *Information and Support Pack for those Bereaved by Suicide and Other Sudden Death* is a comprehensive pack produced by the WA Youth Suicide Advisory Committee (now auspiced by the Ministerial Council for Suicide Prevention) and has been available since 2001¹⁴⁹. It includes information on practical matters, grieving Aboriginal way, books and websites, support services, country services, friends can help, what helps?, early grief and mourning, emotions during bereavement, helping children with grief, for teenagers, questions about grief, suicide bereavement, and the future¹⁵⁰. However, despite its title, it is only

¹⁴⁴ Email from Stephanie Fewster to Lauren Breen, 26th September 2011

¹⁴⁵ <http://journeybeyondroadtrauma.org/>

¹⁴⁶ <http://journeybeyondroadtrauma.org/cms/support-services>

¹⁴⁷ <http://journeybeyondroadtrauma.org/cms/whats-new>

¹⁴⁸ For instance, Western Australian Police Service (n.d.)

¹⁴⁹ Clark, Hillman, and Western Australian Youth Suicide Advisory Committee (2001)

¹⁵⁰ <http://www2.mcsp.org.au/community/resources/bereavement/support.html>

disseminated to next-of-kin and family members when the cause of death is suicide or expected suicide and not to people bereaved through road traffic crashes.

Conclusion

The gaps in social support and services demonstrate that people affected by road traffic crashes in WA are not offered the level and intensity of support granted to those affected by other causes of death or major disasters¹⁵¹. The psychosocial consequences of crashes remain largely unsupported, “yet the shock and horror are equally real”¹⁵². The current model of service delivery relies on the next-of-kin informing other members of the immediate and extended family. The service model assumes that there are open communication channels in families dealing with the sudden and violent death of a loved one, which is often not the case¹⁵³. The Department of Health, along with many of the above services, recognises that existing supports and services are inadequate in meeting the varied needs of people affected by road traffic crashes. While some services are available on state-wide basis, there are generally time delays to access referral services. In addition, professional grief and trauma therapists may not be accessible in many areas of WA. In the absence of a dedicated road trauma support service, appropriate supports can be absent, difficult to identify, costly to access, complicated, and dislocated.

As the above description shows, there is no dedicated road trauma support service in WA to provide the coordinated, timely, and appropriate support that is required and that may be needed over the long-term. Instead, current support services are only available on a very restricted and/or short term basis; many existing service providers are not adequately trained to provide appropriate therapeutic interventions; there is the likelihood of referral from one service to another and then another; access to services is usually not immediate and can require booking days and weeks in advance; and the onus in accessing support falls on the people who need it. The processes involved in recognising a need for support and locating an appropriate service are likely to be particularly challenging when experiencing a trauma, injury, or sudden bereavement. Indeed, support is often not readily accessed by people when they are distressed, anxious, or traumatised^{154,155,156}. Furthermore, people may struggle financially (especially if needing time away from paid work) so they and their dependents may not be able to afford services that incur fees. Furthermore, a single road traffic crash can result in a large number of individuals needing to access trauma support, especially where direct victim numbers are large and/or where large numbers of witnesses are involved. This can significantly stretch local resources and may require additional support service personnel to be called upon to assist from outside the region. A dedicated road trauma support group could significantly assist and help to coordinate the supports required after such road trauma events.

¹⁵¹ Breen (2007)

¹⁵² Williams (1997, p. 18)

¹⁵³ Breen and O'Connor (2011)

¹⁵⁴ Tehrani (2004)

¹⁵⁵ Prigerson, Silverman, Jacobs, Maciejewski, Kasl, and Rosenheck (2001)

¹⁵⁶ Ferguson and Kehoe Watson (2011)

5.0 EFFICACY OF SUPPORT INTERVENTIONS FOR TRAUMA AND BEREAVEMENT

Road trauma victims, witnesses, offenders, family members, friends and colleagues may experience adverse physical, emotional, behavioural and social outcomes. They are susceptible to a range of recognised mental health problems that can be addressed through professional psychotherapeutic interventions and support. This section presents a summary of interventions for trauma and bereavement. This is followed by an overview of two models of service delivery – a public health approach and a community counselling approach.

Trauma interventions

Two post-traumatic health disorders are recognised – PTSD and Acute Stress Disorder (ASD)¹⁵⁷. A comparison of their diagnostic criteria is presented in Table 2.

Table 2

*A Comparison of Diagnostic Criteria for Acute Stress Disorder and Post-Traumatic Stress Disorder*¹⁵⁸

<i>Acute Stress Disorder</i>	<i>Post-Traumatic Stress Disorder</i>
<p>A. Person exposed to a traumatic event in which:</p> <ol style="list-style-type: none"> 1. Person is exposed to actual or threatened death or serious injury for self and others. 2. Person's response involved intense fear, helplessness, or horror. <p>B. Either while experiencing the traumatic event or after the event, the person has three or more dissociative symptoms:</p> <ol style="list-style-type: none"> 1. Sense of numbing, detachment, absence of emotional responsiveness. 2. Reduction in awareness ("being in a daze"). <p>C. At least one re-experiencing symptom.</p> <p>D. Marked avoidance of stimuli that reminds the person of the trauma.</p> <p>E. Marked hyperarousal symptoms.</p> <p>F. Marked distress or role impairments,</p> <p>G. Disturbance lasts for two days to four weeks.</p>	<p>A. Person exposed to a traumatic event in which:</p> <ol style="list-style-type: none"> 1. Person is exposed to actual or threatened death or serious injury for self and others. 2. Person's response involved intense fear, helplessness, or horror. <p>B. At least one re-experiencing symptom.</p> <p>C. At least three avoidance or psychic numbing symptoms.</p> <p>D. At least two hyperarousal symptoms.</p> <p>E. Marked distress or role impairment.</p> <p>F. Disturbance lasts for at least one month.</p>

A range of psychotherapeutic interventions are available for trauma and may be divided into single-session, early interventions provided in the first two weeks following the road trauma event and various multiple session interventions. A review of controlled treatment trials for survivors of motor vehicle crashes revealed:

¹⁵⁷ American Psychiatric Association (2000)

¹⁵⁸ American Psychiatric Association (2000)

1. single-session, early interventions provided in the first two weeks following the road trauma event (e.g., psychological debriefing) were ineffective and may actually increase symptomatology;
2. multiple session early educative and supportive counselling is ineffective and may actually increase symptomatology, but is likely to be effective in the long-term;
3. multiple session cognitive-behaviour therapy administered early to high-risk survivors of road traffic crashes is effective in preventing the later development of PTSD; and
4. multiple session cognitive-behaviour therapy administered to survivors of road traffic crashes with PTSD is effective in treating PTSD¹⁵⁹.

Critical incident debriefing, which involves a review of the traumatic incident, information about common reactions to trauma, and the encouragement of emotional expression, is not effective. For instance, a three-year follow-up of a randomised, controlled trial of debriefing for survivors of road traffic crashes found that the intervention was associated with greater pain, emotional distress, and reduced quality of life¹⁶⁰. Formal interventions in the initial weeks after trauma are not recommended^{161,162}. The Royal Australian and New Zealand College of Psychiatrists recently declared:

Caution is required in the immediate response to avoid revisiting the traumatic events through 'debriefing' as this may compound the trauma. Attention should be directed instead to assisting people to recover with appropriate practical and sympathetic support and acknowledgement of loss and grief¹⁶³.

A short-term intervention showing more promise than debriefing is psychological first aid, which seeks to reduce distress and meet basic needs following a traumatic event. It usually involves engaging with an affected person in a non-intrusive, compassionate and helpful manner, providing immediate safety and comfort, gathering information to determine immediate needs and concerns, providing practical assistance and information, and connecting affected persons with their social support networks¹⁶⁴. However, approximately 15% to 20% of survivors of traumatic events develop serious post-traumatic stress disorders, even after psychological first aid. A recent meta-analysis demonstrated that cognitive-behaviour therapy is the most effective treatment for post-traumatic disorders^{165,166}. Australian guidelines state that "trauma-focussed cognitive behavioural therapy (CBT) and eye movement desensitisation and reprocessing (EMDR) are the treatment of choice for PTSD"; further, they also reduce depression and anxiety symptoms and increase quality of life¹⁶⁷. Typically, 8 to 12 sessions are required. These therapies are also effective when used in conjunction with anxiety management, stress inoculation training, supportive counselling, psychoeducation, and group therapy. What is clear is that, for optimal efficacy, trauma

¹⁵⁹ Blanchard and Hickling (2004)

¹⁶⁰ Mayou, Ehlers, and Hobbs (2000)

¹⁶¹ Australian Centre for Posttraumatic Mental Health (2007)

¹⁶² Forbes et al. (2007)

¹⁶³ <http://www.ranzcp.org/latest-news/look-after-mental-health-in-wake-of-floods.html>

¹⁶⁴ Bateman (2010)

¹⁶⁵ Butler, Chapman, Forman, and Beck (2006)

¹⁶⁶ Roberts, Kitchiner, Kenardy, and Bisson (2009)

¹⁶⁷ Australian Centre for Posttraumatic Mental Health (2007, p. 61)

requires appropriate screening so that only people in need receive interventions, rather than a 'one-size fits-all' approach.

Bereavement interventions

Historical literature articulates grief as a short-term process of 'working through' a relatively distinct, quasi-linear pattern of stages (or phases, tasks, or processes) which culminates in the detachment from the deceased. This construction of grief is not supported by empirical research yet it continues to be accepted by many service providers, lay people, and the media¹⁶⁸. Contemporary grief theories recognise the importance of continuing bonds with the deceased¹⁶⁹, stress that there are individual and sociocultural differences in grief expression¹⁷⁰ identify constructive aspects of loss¹⁷¹, and acknowledge the oscillation between loss-oriented and restoration-oriented aspects of grief¹⁷².

Not all bereaved people suffer a significant and long-term grief reaction following the death of a loved one¹⁷³; however, it is clear that some do exhibit elevated levels of distress. While most people will experience short-lived distress following bereavement, a significant minority (about 10% to 20%) may experience persistent psychiatric difficulties¹⁷⁴. Despite concerns that bereavement is increasingly being medicalised and pathologised¹⁷⁵, the interest in 'disordered' bereavement is growing rapidly. Bereavement Related Disorder is proposed for inclusion in the draft Diagnostic and Statistical Manual of Mental Disorders (DSM), due for publication in 2013, and Prolonged Grief Disorder (formally known as traumatic grief and Complicated Grief Disorder) is under review for inclusion¹⁷⁶. The proposed criteria are show in Table 3. Several factors contribute to the risk of such 'complicated' manifestations of grief. A recent review of risk factors differentiated between factors prior to bereavement such as previous loss, psychiatric history, close relationship with the deceased, attachment style, and exposure to trauma, and factors at the time of death such as mode of death, death preparedness, and a lack of social support¹⁷⁷.

Empirical studies have demonstrated that grief interventions are not always effective. Research has demonstrated that grief interventions for adults with 'normal' grief tend to be minimally to not at all effective and may even result in greater distress^{178,179,180}. This lack of efficacy was also reported in meta-analyses of bereavement interventions aimed at children who are not exhibiting distress^{181,182}. In another review, the authors stated there

¹⁶⁸ Breen and O'Connor (2007)

¹⁶⁹ Klass, Silverman, and Nickman (1996)

¹⁷⁰ Martin and Doka (2000)

¹⁷¹ Neimeyer (2001)

¹⁷² Stroebe and Schut (1999)

¹⁷³ Bonanno, Boerner, and Wortman (2008)

¹⁷⁴ Prigerson, Vanderwerker, and Maciejewski (2008)

¹⁷⁵ Breen and O'Connor (2007)

¹⁷⁶ www.dsm5.org

¹⁷⁷ Lobb, Kristjanson, Aoun, Monterosso, Halkett, and Davies (2010)

¹⁷⁸ Jordan and Neimeyer (2003)

¹⁷⁹ Piper, Ogrodniczuk, Joyce, Weideman, and Rosie (2007)

¹⁸⁰ Schut, Stroebe, van den Bout, and Terheggen (2001)

¹⁸¹ Currier, Holland, and Neimeyer (2007)

¹⁸² Curtis and Newman (2001)

is a lack of empirical evidence supporting primary prevention interventions for ‘uncomplicated’ reactions such as:

...crisis teams visiting family members within hours of the loss, mutual-help groups with the goal of fostering friendship, programs to educate bereaved persons about the tasks of working through one’s grief, cognitive-restructuring and behavioural-skills programs, treatment involving the sharing of information, emotions, and support, and brief group psychotherapy.¹⁸³

The offer of bereavement services irrespective of need stems from the erroneous belief that emotional disclosure is necessary to achieve recovery from bereavement. Furthermore, grief counsellors do not always have adequate training and professional development opportunities in relation to bereavement interventions¹⁸⁴, and universal bereavement services potentially disrupt the natural course of grieving and interfere with support from natural social support networks¹⁸⁵.

Table 3

*Proposed Diagnostic Criteria for Prolonged Grief Disorder*¹⁸⁶

<i>Definition</i>	
A.	Event: Bereavement (loss of a significant other).
B.	Separation distress: The bereaved person experiences yearning (e.g., craving, pining, or longing for the deceased; physical or emotional suffering as a result of the desired, but unfulfilled, reunion with the deceased) daily or to a disabling degree.
C.	Cognitive, emotional, and behavioural symptoms: The bereaved person must have five (or more) of the following symptoms experienced daily or to a disabling degree: <ol style="list-style-type: none"> 1. Confusion about one’s role in life or diminished sense of self (i.e., feeling that a part of oneself has died). 2. Difficulty accepting the loss. 3. Avoidance of reminders of the reality of the loss. 4. Inability to trust others since the loss. 5. Bitterness or anger related to the loss. 6. Difficulty moving on with life (e.g., making new friends, pursuing interests). 7. Numbness (absence of emotion) since the loss. 8. Feeling that life is unfulfilling, empty, or meaningless since the loss. 9. Feeling stunned, dazed or shocked by the loss.
D.	Timing: Diagnosis should not be made until at least six months have elapsed since the death.
E.	Impairment: The disturbance causes clinically significant impairment in social, occupational, or other important areas of functioning (e.g., domestic responsibilities).
F.	Relation to other mental disorders: The disturbance is not better accounted for by major depressive disorder, generalised anxiety disorder, or posttraumatic stress disorder.

However, these intervention studies, along with a recent comprehensive meta-analysis of 61 controlled studies of psychotherapeutic interventions for bereavement¹⁸⁷ demonstrate

¹⁸³ Hansson and Stroebe (2003, p. 519)

¹⁸⁴ Breen (2011)

¹⁸⁵ Aoun, Breen, O’Connor, Rumbold, and Nordstrom (in press)

¹⁸⁶ Prigerson et al. (2009)

greater efficacy for interventions that are targeted at griever with higher levels of distress (e.g., clinical symptomatology). Importantly, recent empirical studies do indicate support for targeted interventions for people who meet the criteria for Prolonged Grief Disorder^{188,189}. In sum, despite the interest in and the proliferation of grief interventions, empirical research has shown that the interventions are likely to be of benefit, but only for grief that is deemed 'at-risk' or 'complicated'. In fact, interventions are likely to be deleterious for 'normal' grief.

A public health approach to support service delivery

Road safety tends to be conceptualised as a component of the transport sector but is better conceptualised as a public health concern¹⁹⁰. The public health model outlines three levels of intervention that target different populations – universal interventions are intended for the total population of interest, selective interventions target people and groups at increased risk, and indicated interventions are for people showing signs of disorder. Similarly, three levels of intervention have been proposed for bereavement care according to need¹⁹¹: primary – targeting all bereaved people; secondary – targeting people at-risk of complications of bereavement; and tertiary – targeting people with complicated bereavement.

The United Kingdom's National Institute for Health and Clinical Excellence proposed a three-tiered approach to bereavement according to the needs of families¹⁹² (Table 4). Component 1 comprises information from service providers and compassion from the bereaved person's social networks, including family and friends. A smaller proportion would benefit from non-specialist social and therapeutic support from source such as volunteer bereavement workers, bereavement mutual-help groups, and faith-based and other community groups (Component 2). An even smaller proportion would gain from specialist psychotherapeutic interventions such as counselling, mental health services, bereavement services, or psychotherapy (Component 3). Referral pathways must be available between components as needs emerge¹⁹³.

These levels of intervention are supported empirically by research reviewed above demonstrating that grief interventions for those with 'normal' grief tend to be minimally, if at all, effective and may even result in harm, unless directed only to people with higher levels of distress. The provision of high-quality bereavement support for those with complex needs and those at-risk of complex needs may prevent further pathology¹⁹⁴ and significantly reduce use of health services, particularly visits to general practitioners¹⁹⁵. Furthermore, they are supported by the differentiation between grief support (informal compassion and information from people who do not have professional bereavement training), grief

¹⁸⁷ Currier, Neimeyer, and Berman (2008)

¹⁸⁸ Boelen, de Keijser, van den Hout, and van den Bout (2007)

¹⁸⁹ Shear, Frank, Houck, and Reynolds (2005)

¹⁹⁰ World Health Organization (2004)

¹⁹¹ Schut et al. (2001)

¹⁹² National Institute for Health and Clinical Excellence (2004)

¹⁹³ Aoun et al. (2011)

¹⁹⁴ Prigerson et al. (2001)

¹⁹⁵ Vanderwerker, Laff, Kadan-Lottick, McColl, and Prigerson (2005)

counselling (provided by a trained professionals), and grief therapy (provided by trained professionals to people with mental health concerns)¹⁹⁶.

Table 4

Three-Component Model of Bereavement Care

<i>Type of Support</i>	<i>Target Population</i>	<i>Source of Support</i>
1 Information and compassion	All bereaved (100%)	Family and friends (information supplied by health and social care professionals)
2 Non-specialist support	Those at-risk of developing complex needs (33%)	Trained volunteers, mutual-help groups, other community supports
3 Professional psychotherapeutic interventions	Those with complex needs (10%)	Mental health services, bereavement and trauma services, specialist psychotherapy

Social support is important for adaptation to, and recovery from, bereavement. Most of this comes from natural sources of social support – family and friends¹⁹⁷. However, not everyone has adequate social support networks, and in some cases, particularly in stigmatising bereavement, there may be a breakdown of these networks¹⁹⁸ and therefore peer and professional support is more likely to be required. The application of a public health model to bereavement care suggests that services should offer Component 1 to all families, but reserve access to Components 2 and 3 according to identified need. Furthermore, service providers require training to recognise need and be able to refer appropriately to services offering Components 2 and 3. A dedicated road trauma support service provides an ideal mechanism for the provision of components 2 (non-specialist supports) and 3 (professional specialist supports).

Community counselling model

A community counselling model has been proposed for the delivery of multiple support services¹⁹⁹. In this model, service provision may be direct and indirect, and provided to clients and the community (Table 5). The indirect services complement the direct services that provide traditional supports to clients. As such, it goes beyond the traditional helping paradigm that focuses almost exclusively on one-to-one interventions.

Direct services aimed at the community involve interventions that reduce the need for professional one-on-one assistance. Examples include educational seminars and workshops providing information. Direct client services include the provisions of individualised, therapeutic, and professional interventions aimed at people in need and at-risk of need,

¹⁹⁶ Neimeyer (2009)

¹⁹⁷ Benkel, Wijk, and Molander (2005)

¹⁹⁸ Breen and O'Connor (2011)

¹⁹⁹ Lewis, Lewis, Daniels, and D'Andrea (2003)

including specialist psychotherapy. Indirect community services involve activities such as influencing public policy in order to support the community and creating systemic change. Indirect client services involve client advocacy and consultation, such as the provision of education to the wider community and supporting the development of mutual-help groups. The model offers a unified approach to assist services to develop a multi-faceted and complementary combination of programmes and interventions that empower individuals to more readily access these services.

Table 5

Community Counselling Model

<i>Support Type</i>	<i>Community Services</i>	<i>Client Services</i>
Direct	Preventative education	One-on-one interventions, outreach to vulnerable clients
Indirect	Influencing public policy	Client advocacy, consultation

Conclusion

Mental health research indicates that post-trauma supports and services can be very effective in helping people cope with their losses and in promoting optimal vocational, familial, and social functioning following a traumatic event. Access to peer support and to professional interventions, when required, can facilitate a person's ability to engage normal coping skills and to achieve their maximum potential in resuming their family, work and social functioning.

However, the offer of universal professional support to people affected by road traffic crashes, *regardless of need*, is not likely to be effective (or economical). In proposing a public health approach to the provision of road trauma support services, we are guided by the dual imperative of meeting support needs while remaining cost-effective. Importantly, the model provides an evidence-base for the allocation of appropriate resources while meeting the direct and indirect needs of people affected by road traffic crashes in WA. The public health approach offers the foundation for determining the types of services and supports offered, depending on need. Additionally, the community counselling model provides an exemplar for service delivery that combines direct and indirect services to individuals and communities.

6.0 METHOD OF INVESTIGATION

The multidisciplinary research team has extensive expertise in complex research involving multiple stakeholders for a large range of industry partners and demonstrated successful administration, management, and completion of research projects (see Appendix A). The project was approved by the Curtin University Human Research Committee (Approval Number HR 29/2011), in accordance with the National Health and Medical Research Council (NHMRC) National Statement on Ethical Conduct in Research Involving Humans, in March 2011²⁰⁰. The project occurred in three main phases (see Appendix B).

Phase 1: Establishment of a stakeholder reference group

A stakeholder reference group was essential to guide the study (see Section 1). Members were selected in consultation with the Department of Health (WA) and included representatives from government and non-government organisations²⁰¹ as well as community members with personal experiences of road traffic crash consequences (the latter received a voucher in recognition of their time and associated expenses). The reference group met three times throughout the study (November 2010, June 2011, and September 2011). Notes from each of the meetings are included in Appendix C.

Phase 2: Investigation of support services for road trauma

The second phase of the project involved the investigation and research of all existing road trauma support programs in Australia. The investigation of these services was essential in determining the parameters of operation for a similar service in WA. The review entailed accessing their websites, annual reports, service brochures, evaluations, and any other available documentary materials, as well as telephone interviews with key personnel at each service. A structured protocol (Appendix D) was used for the documentary analysis and the interviews to ensure consistency in the collection of data across different jurisdictions and services. Particular attention was paid to:

- history, including how each service was introduced and has developed over time;
- promotion of services, both to service users and referring professionals;
- referral pathways to and from each service;
- fees charged for services;
- scope and duration of service delivery (i.e., who for, including gender, Indigenous status, and cultural and linguistically-diverse status of clients; how many, including total client numbers and breakdown for bereaved, injured, witnesses, and others; what for, and for how long) and whether and how other services such as advocacy, research, and road safety education are delivered;
- recruitment, training, and appointment of staff, both professional counsellors and peer supporters;
- resources required, including accommodation, administration, computing, communications and promotional materials;
- metropolitan and regional service delivery;

²⁰⁰ The project was also approved by Edith Cowan University Human Research Ethics Committee in October 2010, as Dr Breen was employed there at the time.

²⁰¹ The Office of Road Safety and HeadWest were invited to be represented on the stakeholder reference group but declined to participate.

- set up and annual costs of each service and where funding is accessed, both initially and ongoing;
- service evaluation procedures; and
- effectiveness of services.

Each service was described and summarised, with data collection occurring in April to June 2011. These summaries were disseminated to the stakeholder reference group in June 2011. Three services, chosen in consultation with the stakeholder reference group, were visited by the first author in July and August 2011. The services were – Road Trauma Support Services (Victoria), Road Trauma Support Tasmania, and Road Trauma Support Team South Australia. Face-to-face interviews were conducted with staff members and observations were made of the service setting.

Phase 3: Report writing and dissemination

The third phase of the project entailed the preparation of a written report outlining the following points:

1. recommended road trauma support roles and services and evidence supporting their effectiveness (including a review of interstate road trauma support services);
2. preferred options and recommendations to establish sustainable road trauma support service in WA, including possible service providers;
3. options to facilitate the delivery of accessible peer support and professional counselling across metropolitan and regional WA;
4. recommended mechanism to advertise and to promote road safety peer support services state-wide;
5. the scope, extent and duration of cost-free support for victims, offenders, witnesses, family and friends and other community members;
6. criteria for selecting, training and appointing professional and peer support counsellors as required;
7. the extent and delivery of associated advocacy, research and road safety education roles;
8. resource requirements, including accommodation, administration, computing, communications and promotional materials;
9. estimated costs associated with establishing and sustaining recommended road trauma support services in WA, and recommended funding providers;
10. stakeholder details and contacts, including government, non-government organisations, industry and community groups;
11. an evaluation and reporting framework to monitor, assess and provide constructive feedback on the effectiveness of the WA road trauma support service, on an ongoing basis; and
12. an outline of essential steps to ensure the successful introduction of sustainable road trauma support services across WA.

The draft report was disseminated to Department of Health, the three visited services, and to the stakeholder reference group in September 2011 (via email and posted hard copy). Members of the group were encouraged to provide comments and suggestions. All suggestions for change were reviewed by the researchers and every effort was made to incorporate these into the final report.

7.0 ROAD TRAUMA SUPPORT SERVICES ELSEWHERE IN AUSTRALIA

Road trauma support services are available in several other Australian states. A summary of each service is presented below.

Road Trauma Support Services Victoria

Road Trauma Support Services Victoria (RTSSV), formerly the Road Trauma Support Team Victoria²⁰², is a community-based, not-for-profit organisation offering a state-wide counselling, education and support service to people whose lives have been affected by road trauma. Its mission is “To reduce the incidence and impact of road trauma by supporting, educating and empowering”²⁰³. The service is in the process of registering its name nationally²⁰⁴. The services head office is in Blackburn, Melbourne, and it has some regional offices. The Blackburn premises is smaller than what is required but is located close to a train station; accessibility is important for people who have been injured in a road traffic crash and/or do not/cannot drive following a road traffic crash²⁰⁵.

The RTSSV has a patron (Beverley Brock), an ambassador (Jeanette Suhr OAM), a Board of Management (President, Vice-President, Secretary, Treasurer, Ordinary Members, and a Volunteer Representative), and staff (Executive Officer, Accountant, Office Administrator, Manager of Support Services, Manager of Education Programmes, Manager of Community Relations, three counsellors, and a Manager of Volunteers, as well as a team of volunteers; some of these roles are occupied by people who have been personally affected by road trauma)²⁰⁶.

The RTSSV was founded in 1994 after a group of people who had been directly affected by road trauma joined with professionals working in the area to provide a specialist support service. Jeanette Suhr, with the support and assistance of Colleen Hall, founder of the Road Trauma Support Team in Tasmania, set up Road Trauma Support Team Victoria. Along with 21 other volunteers, \$5,000, a mobile phone and an office set up in her home, Jeanette and her team began providing support to those who had been affected by road trauma. During the last 17 years, RTSSV has grown and now offers state-wide counselling and education services²⁰⁷ and may be contacted by telephone on a free call number.

The RTSSV is underpinned by four guiding principles²⁰⁸:

1. Integrity and Compassion – RTSSV strives to act with integrity, warmth and compassion in its interaction with the Victorian community including clients, staff and volunteers;
2. Quality Programmes – RTSSV is committed to delivering high quality programmes that are relevant to the community. Services are evidence-based and are regularly evaluated and modified to meet the changing needs of the community;

²⁰² Downes (2010)

²⁰³ <http://www.rtssv.org.au/about-us/our-mission>

²⁰⁴ Face-to-face interview with Paul Ashton, Chief Executive Officer of RTSSV, 12th July 2011

²⁰⁵ Face-to-face interview with Paul Ashton, Chief Executive Officer of RTSSV, 12th July 2011

²⁰⁶ Road Trauma Support Services (n.d.)

²⁰⁷ <http://www.rtssv.org.au/about-us/our-history>

²⁰⁸ <http://www.rtssv.org.au/about-us/our-mission>

3. Work with our Partners – RTSSV will continue to develop and nurture partnerships with key organisations in the commitment to supporting those affected by road trauma, and the desire to deliver a strong road safety message to the Victorian community; and
4. Sustainability – At all times, RTSSV will manage resources responsibly to ensure the service continues to be available to the community. Programmes are based upon by sustainable funding, staffing, and knowledge.

The RTSSV is promoted, both to service users and referring professionals, in various ways, including presentations at key professional fora, increased dissemination of promotional brochures and cards, and targeted media coverage²⁰⁹. However, the service is unable to promote itself in the wider community as it is unable to cope with an increase in service demand²¹⁰. The RTSSV has strong partnerships with sponsors and supporters that also promote its services, including the Magistrates' Court of Victoria, Royal Automobile Club Victoria (RACV), Transport Accident Commission, and Victoria Police²¹¹. In addition, the RTSSV has an excellent website. It is easy to navigate and obtain information and resources such as the quarterly newsletter, *Shoulder to Shoulder*, an events calendar, media releases, annual reports, and brochures. The RTSSV recently launched a Facebook page to inform the public of the services and promote road safety, especially to younger people who are more at risk of being involved in road traffic crashes²¹².

The RTSSV provides two main types of services – counselling and support, and education. Counselling and support services are provided free of charge to people who have been affected directly or indirectly by motor vehicle crashes including bereaved family members, friends and colleagues, injured people and their carers, drivers, passengers, witnesses and people first on scene²¹³, including emergency service personnel. Referrals to the RTSSV counselling and support services come from a variety of sources – Victoria Police (27% of referrals), Transport Accident Commission (13%), family/friends of the client (13%), agencies (10%), hospitals (6%), Internet (3%), emergency services (2%), self-referral (2%), other sources (10%), and unknown sources (14%)²¹⁴. Counselling services received 443 new referrals during 2009-2010 (up from 366 in 2008-2009 and 352 in 2007-2008) and 1442 sessions were conducted during 2009-2010²¹⁵. Telephone counselling accounted for 75% of consultations with the remaining 25% of sessions performed face-to-face. Services are private and confidential and are provided as long as they are needed. Counselling is provided to various client groups – bereaved (25% of clients), secondary consultation with service providers and others in relation to road trauma issues (25%), drivers (17%), witnesses/first on scene (16%), injured (7%), family/friends (7%), and other (3%)²¹⁶.

²⁰⁹ Road Trauma Support Services (n.d.)

²¹⁰ Face-to-face interview with Paul Ashton, Chief Executive Officer of RTSSV, 12th July 2011

²¹¹ <http://www.rtssv.org.au/how-help/corporate-partners-and-sponsors>

²¹² RTSSV quarterly newsletter *Shoulder to Shoulder*, Summer 2011 from http://www.rtssv.org.au/sites/www.rtssv.org.au/files/RTSSV%20Summer%20s-2-2_1.pdf

²¹³ Road Trauma Support Services (n.d.)

²¹⁴ Road Trauma Support Services (n.d.)

²¹⁵ Road Trauma Support Services (n.d.)

²¹⁶ Road Trauma Support Services (n.d.)

The RTSSV has developed a number of resources for people affected by road trauma – *Grief following road trauma*²¹⁷, *Drivers and road trauma*²¹⁸, *First on the scene and witnesses of road trauma*²¹⁹, and *How can I help my child?*²²⁰ and *Friends and family can help*²²¹. These are available via download in PDF format by clicking on the relevant website link and hard copies may be ordered via completion of an online form, or faxing the form to the office, or by telephoning the service²²².

In addition to the counselling and support services, the RTSSV delivers a range of education programs addressing the behaviours and attitudes of drivers in order to reduce the incidence of crashes and the associated trauma and grief. These education programmes are delivered to community, school, and business groups by trained educators, emergency service personnel, and volunteers who talk about their personal experience²²³. Road Trauma Awareness Seminars are delivered in conjunction with the Magistrates' Court of Victoria to traffic offenders. Offenders pay a fee to attend the one-day seminar²²⁴, which also acts as a source of revenue for the RTSSV. The seminar fee recently increased from \$200 to \$350²²⁵; this fee increases to \$500 for second-time offenders and will be higher again for continuing offenders²²⁶. In the year 2009-2010, 91 of these seminars were held in 12 venues with 1166 traffic offenders participating. This was a significant increase from 826 participating offenders in 2008-2009²²⁷. Additionally, the Youth Traffic Offenders Programme aims to educate young offenders on the dangers and long-term consequences of careless driving. In 2009/10, four Youth Road Trauma Awareness Programmes, each running for six weeks, were completed, with 41 young people graduating from the course²²⁸.

The RTSSV engages with people who have personal experience in the effects of crashes and uses this expertise in both their support and education services²²⁹, including peer support (personal support from a volunteer who may have been involved in a similar situation), bereavement support workshops, facilitated support groups, community education sessions relating to grief and trauma²³⁰, and the Road Trauma Awareness Seminars²³¹. The presence

²¹⁷ <http://www.rtssv.org.au/sites/www.rtssv.org.au/files/Grief%20following%20road%20trauma%20-%20Jan%202011.pdf>

²¹⁸ <http://www.rtssv.org.au/sites/www.rtssv.org.au/files/Drivers%20and%20road%20trauma%20-%20Jan%202011.pdf>

²¹⁹ <http://www.rtssv.org.au/sites/www.rtssv.org.au/files/First%20on%20the%20scene%20and%20witnesses%20of%20road%20trauma%20-%20Jan%202011.pdf>

²²⁰ <http://www.rtssv.org.au/sites/www.rtssv.org.au/files/How%20can%20I%20help%20my%20child%20-%20Jan%202011.pdf>

²²¹ <http://www.rtssv.org.au/sites/www.rtssv.org.au/files/Friends%20and%20family%20can%20help%20-%20Jan%202011.pdf>

²²² <http://www.rtssv.org.au/publications>

²²³ <http://www.rtssv.org.au/about-us>

²²⁴ Seminar application form http://www.rtssv.org.au/sites/www.rtssv.org.au/files/Web%20-%20booking%20form_print_0.pdf

²²⁵ Face-to-face interview with John Downes, Manager of Support Services, RTSSV, 12th July 2011

²²⁶ Face-to-face interview with Paul Ashton, Chief Executive Officer of RTSSV, 12th July 2011

²²⁷ Road Trauma Support Services (n.d.)

²²⁸ Road Trauma Support Services (n.d.)

²²⁹ <http://www.rtssv.org.au/about-us>

²³⁰ <http://www.rtssv.org.au/counselling-and-support/support>

²³¹ Seminar application form http://www.rtssv.org.au/sites/www.rtssv.org.au/files/Web%20-%20booking%20form_print_0.pdf

of volunteers in education programmes is sometimes more effective than ‘facts and figures’ due to their personal experiences. These volunteers are selected carefully and trained in their roles. For instance, in the year 2009-2010, the RTSSV trained 22 new volunteer speakers and emergency service speakers for its education programmes. Training for speaking in the education programmes is six hours over two evenings, followed by observing an RTAS programme and then delivering their personal story. Training includes the role of speaker, presentation skills, and putting their story into words. A final training review session provides the opportunity for the volunteers to reflect on their involvement and seek feedback²³². The volunteers’ own trauma experience must be at least two years previously and they can do no more than one session per month, as the effects of volunteers ‘reliving’ trauma is not well-documented²³³. The volunteers received motor vehicle reimbursement of 74 cents per kilometre travelled²³⁴.

Professional Development activities undertaken by counselling staff in the year 2009-2010 include Level 2 Acceptance and Commitment Therapy training, and Department of Health and Ageing Level 3 Training in Core Interventions for Common Mental Health Problems following Trauma and Disaster. The RTSSV also provides staff supervision and development, and previously engaged Dr Rob Gordon, trauma specialist, who provided group sessions with staff to reflect on clinical aspects of grief and trauma counselling using specific case examples^{235,236}. The counsellors engage in internal and external supervision on a regular basis²³⁷.

The RTSSV has commenced involvement in three new initiatives. The first, in partnership with the RACV, is the “A Warm Embrace” project that aims to increase accessibility of support for those affected by road trauma in outer metropolitan and regional areas of Victoria. Face-to-face counselling is currently available only at the RTSSV’s main office in Blackburn North, Melbourne. The project explores web-based, group support options and trialling face-to-face counselling in additional locations around the state²³⁸. The second, in partnership with Victoria Police, is the “Support at the Time of Need” Project. The project resulted in the production of a user-friendly, foldout card called *After the Crash* outlining the signs and symptoms of trauma and how to access all-important counselling support²³⁹, which is disseminated by Police to people affected by road trauma²⁴⁰. The third, also in partnership with Victoria Police, is a trial of an e-referral system provided by SupportLink, which is a private company in Canberra. The trial has so far yielded positive feedback from the police officers as referrals to victims of a road trauma can be made any time of the day or night, and usually up to six referrals have been made from most road traffic crashes²⁴¹. So

²³² Road Trauma Support Services (n.d.)

²³³ Face-to-face interview with Maria Thompson, Manager of Volunteers, RTSSV, 12th July 2011

²³⁴ Face-to-face interview with Maria Thompson, Manager of Volunteers, RTSSV, 12th July 2011

²³⁵ Road Trauma Support Services (n.d.)

²³⁶ Face-to-face interview with John Downes, Manager of Support Services, RTSSV, 12th July 2011

²³⁷ Face-to-face interview with John Downes, Manager of Support Services, RTSSV, 12th July 2011

²³⁸ Road Trauma Support Services (n.d.)

²³⁹ <http://www.rtssv.org.au/news/2011/01/support-time-need-joint-project-victoria-police>

²⁴⁰ RTSSV quarterly newsletter *Shoulder to Shoulder*, Autumn 2010 from <http://www.rtssv.org.au/sites/www.rtssv.org.au/files/Road%20Trauma%20Support%20Services%20Autumn%202010%20Newsletter.pdf>

²⁴¹ Telephone interviews with John Downes, Manager of Support Services, RTSSV, 23rd May 2011 and Sarah Young, SupportLink State Coordinator for the Australia Capital Territory 24th May 2011

far, the trial is not state-wide but it has led to an increase in referrals to the service, with each road traffic crash yielding between one and four referrals²⁴².

Client satisfaction with counselling services is evaluated by survey approximately every six months. Satisfaction with services was rated above 90% on eight of nine evaluation categories; the exception was “Ease of finding the service” (67%). Overall satisfaction rating was 91%. An external evaluation conducted in March – April 2010 demonstrated that the RTSSV met good counselling procedural standards and utilises a number of innovative tools and practices particularly relevant to their client group. Several recommendations were made to improve the effectiveness and efficiency of a number of counselling activities.²⁴³

The RTSSV commenced following an initial grant of \$5,000 from the Victims Referral and Assistance Service²⁴⁴. For the year ending 30th June 2010, the annual income was \$682,462 and expenditure was \$625,886, resulting in a surplus of \$56,676. Income consisted of fees and charges (\$209,166), grants (\$370,491), fundraising (\$439), donations (\$94,682), and interest (\$7,684). Expenditure was salaries and wages (\$418,247), rent and venue hire (\$48,525), superannuation (\$33,593), travel, accommodation, parking, and motor vehicle expenses (\$12,991), minor equipment, service, and maintenance (\$12,054), depreciation (\$11,807), utilities (10,947), postage and stationery (\$10,795), telephone (\$10,578), counselling resources (\$9,681), volunteer expenses (\$7,131) and training and development (\$6,575), human resources recruitment, meeting, and other expenses (\$6,397), work cover (\$4,610), security and insurance (\$4,847), Time of Remembrance annual ceremony (\$4,061), bank charges (\$3,142), cleaning (\$2,790), advertising and branding (\$2,386), office/business expenses (\$2,050), audit fees (\$1,880), support groups and memberships (\$356), entertainment and gifts (\$348), and fundraising expenses (495)²⁴⁵. The bulk of funding is obtained from the Transport Accident Commission²⁴⁶ (about 54%). Furthermore, it is important to note that, while its annual budget is over \$600,000 per year, the key reason it remains viable is low staff salaries paid as per the Social and Community Services Award^{247,248}.

Ideally, the service would operate with a budget of \$1-1.5 million per year²⁴⁹. Currently the service cannot offer support to children²⁵⁰, does not offer parity in service delivery between regional and metropolitan services; does not have the resources to provide quality recruitment, training, and supervision of its volunteers, particularly in regional areas²⁵¹; and it does not have the resources to compile a resource directory to facilitate referral and information exchange between services²⁵².

²⁴² Face-to-face interview with John Downes, Manager of Support Services, RTSSV, 12th July 2011

²⁴³ Evans (2010)

²⁴⁴ Downes (2010)

²⁴⁵ Road Trauma Support Services (n.d.)

²⁴⁶ Downes (2010)

²⁴⁷ Face-to-face interview with John Downes, Manager of Support Services, RTSSV, 12th July 2011

²⁴⁸ Face-to-face interview with Maria Thompson, Manager of Volunteers, RTSSV, 12th July 2011

²⁴⁹ Face-to-face interview with Paul Ashton, Chief Executive Officer of RTSSV, 12th July 2011

²⁵⁰ Face-to-face interview with Paul Ashton, Chief Executive Officer of RTSSV, 12th July 2011

²⁵¹ Face-to-face interview with Maria Thompson, Manager of Volunteers, RTSSV, 12th July 2011

²⁵² Face-to-face interview with Maria Thompson, Manager of Volunteers, RTSSV, 12th July 2011

Road Trauma Services Queensland

The Road Trauma Services Queensland's (RTSQ) mission statement is to "Engage the emotional conscience of the driving community to take personal responsibility in reducing road carnage and honour our commitment to the youth of Australia"²⁵³. The RTSQ was established in late 2002 when a group of concerned individuals with direct experience of road trauma teamed with professionals working in the area to provide a free, confidential counselling service to those affected by road trauma in the community. The RTSQ is tax-exempt, modelled on the Road Trauma Support Team, formed in Tasmania in 1989, and is based on the Sunshine Coast. The RTSQ committee consists of a President, Vice-President, Secretary, Treasurer, two assistant secretaries, media coordinator, auditor and honorary solicitor; all provide their time and skills on an unpaid basis²⁵⁴. The committee and members meet on a Monday evening once a month at one of two venues²⁵⁵. The RTSQ does not have a head office and instead is run from committee members' homes. Although the RTSQ's website is user-friendly, information is limited. The website includes a PO Box address, a mobile telephone number and landline telephone number (which diverts to the home number of the secretary). The committee is hopeful of having premises by the end of 2011²⁵⁶.

The primary aim of the organisation is to provide a free, confidential counselling service to people who have been involved in, been witness to, or lost a loved one in a road trauma incident²⁵⁷. To date, RTSQ has provided free counselling to more than 180 people affected by road trauma, with the majority of these occurring in the past two years²⁵⁸. Two professionals (a psychologist and a counsellor, both with grief and loss training) currently volunteer their time and expertise. Clients may have as many face-to-face interviews as they require²⁵⁹. The website hosts one brochure called *Some of the normal reactions to grief and trauma*, which outlines typical trauma reactions and coping suggestions²⁶⁰. The face-to-face counselling occurs at the workplaces of the counsellors. Due to its reliance on volunteers and lack of funding, the RTSQ is available only in the Sunshine Coast and Gympie areas of Queensland rather than state-wide. The exception is telephone counselling, which is available throughout Queensland²⁶¹.

In addition to the counselling service, RTSQ volunteers participate in the delivery of the Safe Driving Awareness Programs in the North Coast region of Queensland, where the consequences of driving practices are discussed. The volunteers, all of whom have directly suffered a loss from road traffic crashes, attend a facilitator's course prior to their involvement with the RTSQ. The volunteers and Emergency Services personnel give first-hand accounts of how a road trauma incident has affected their lives. One speaker is Anita Rowland, a Queensland police officer who was in a horrific road crash with her two sons; she

²⁵³ <http://www.roadtraumaservicesqld.org/>

²⁵⁴ <http://www.roadtraumaservicesqld.org/Committee.html>

²⁵⁵ <http://www.roadtraumaservicesqld.org/Meetings.html>

²⁵⁶ Telephone interview with Heather Grote, Secretary of RTSQ, 11th April 2011

²⁵⁷ <http://www.roadtraumaservicesqld.org/AboutUs.html>

²⁵⁸ <http://www.roadtraumaservicesqld.org/AboutUs.html>

²⁵⁹ Telephone interview with Heather Grote, Secretary of RTSQ, 11th April 2011

²⁶⁰ <http://www.roadtraumaservicesqld.org/files/Download/Some%20of%20the%20normal%20reactions%20to%20grief%20and%20trauma.pdf>

²⁶¹ Telephone interview with Heather Grote, Secretary of RTSQ, 11th April 2011

and one of her sons were seriously injured and her other son died²⁶². The programmes are held on an approximately monthly basis at RSL Clubs, high schools, and other venues and cost \$2 to attend²⁶³. Approximately 4700 people, from the Sunshine Coast and Gympie region, have attended these workshops since commencing in December 2006. The program is now mandatory for traffic offenders through the justice system and the attendance of offenders must be signed off. The RTSQ is attempting to increase the awareness of the Safe Driving Programs this year and is considering an increase to the current charge of \$2 to make the service more viable. Mining sites have requested the delivery of the Safe Driving Awareness Programs²⁶⁴. Trained RTSQ volunteers also attend Youth Justice Conferences, in Brisbane and the Sunshine Coast region, to assist young people charged over road incidents²⁶⁵.

The RTSQ is now on Facebook and is establishing links with Lifeline²⁶⁶. Further attempts to collaborate with other organisations have had limited success. The RTSQ is currently working with ambulance officers to provide them with cards to disseminate at crash scenes to assist people who are struggling later to follow through and seek help. However, at this time there is some resistance from some of the ambulance officers to carry a card. The RTSQ has attempted to work with Queensland Police but experienced difficulties in relation to the 'red tape' restrictions that the Police tried to place on previous projects. The Queensland Police did express an intention to operate the service but the RTSQ volunteers felt that the service would be compromised with 'red tape' and rejected the proposal²⁶⁷.

The RTSQ lobbies for state and federal government support but currently receives limited government support. Instead, the service relies on donations and fundraising from private companies and community groups²⁶⁸. In 2011, the RTSQ aims to increase the community's awareness of the service by working towards a viable service based on the Victorian model. However, funding of the service is the main concern and the service is developing a business plan to increase the viability of the service and aid in its promotion²⁶⁹.

Since its inception and incorporation in 2002, the RTSQ has lobbied for ongoing funding state and/or federal government funding but to date has not received any funding²⁷⁰. However, the website does link to Queensland Police, The Sunshine Coast Private Hospital, Rhema FM (a radio station), AAMI (an insurance company), Gambling Community Benefit Fund (a section of the Queensland Government), and Grace and Jessica's Road Smart Day²⁷¹. The Sunshine Coast Private Hospital provides a venue and refreshments for meetings, and three mobile phones for the use of counsellors and the committee²⁷². A freecall number was established on the 9th June 2011 and this is paid for by a donation of \$1,500 from the

²⁶² <http://www.anitarowland.com.au/website/index.html>

²⁶³ <http://www.roadtraumaservicesqld.org/Programs.html>

²⁶⁴ Telephone interview with Heather Grote, Secretary of RTSQ, 11th April 2011

²⁶⁵ <http://www.roadtraumaservicesqld.org/AboutUs.html>

²⁶⁶ Telephone interview with Heather Grote, Secretary of RTSQ, 11th April 2011

²⁶⁷ Telephone interview with Heather Grote, Secretary of RTSQ, 11th April 2011

²⁶⁸ Telephone interview with Heather Grote, Secretary of RTSQ, 11th April 2011

²⁶⁹ Telephone interview with Heather Grote, Secretary of RTSQ, 11th April 2011

²⁷⁰ <http://www.roadtraumaservicesqld.org/Sponsors.html>

²⁷¹ <http://www.roadtraumaservicesqld.org/Sponsors.html>

²⁷² Telephone interview with Heather Grote, Secretary of RTSQ, 11th April 2011

Sunshine Coast Private Hospital²⁷³. AAMI gave \$2,500 to the RTSQ in 2006 and an additional \$10,000 in 2009²⁷⁴. The Gambling Community Benefit Fund gave \$5,274.66 to the RTSQ in July 2009²⁷⁵. Mining companies have donated \$5,000²⁷⁶. In 2007, Rhema FM coordinated a sponsorship day at a major shopping centre on the Sunshine Coast. Patrons of the centre obtained information about, and donated to, the RTSQ²⁷⁷. This funding is used to reimburse committee members, counsellors, and volunteers for their costs such as fuel, paper, and telephone²⁷⁸. Additionally, Channel Seven in Queensland has provided free advertising for the service²⁷⁹.

Annual reports, newsletters and other publications, information on the service's income and expenditure, referral pathways to and from the service, client groups and numbers in receipt of counselling services and for how long, and service evaluation data, are not available.

Road Trauma Support Team of South Australia

The Road Trauma Support Team of South Australia (RTSTSA) was established in 2002 after the death of four-year-old Ella Wood²⁸⁰. The RTSTSA operates from a head office in Thebarton, Adelaide; the premises are small and difficult to find from the road. The RTSTSA's website home page includes a mobile telephone number that is monitored 9am to 5pm 7 days a week by the Secretary and a free call 1800 telephone number²⁸¹. Newsletters are available for downloading and printing²⁸². The website links to website of Disability South Australia, South Australia Ambulance, Motor Accident Commission, South Australian Police, South Australian Country Fire Service, and Journey Beyond Road Trauma²⁸³ and triple 0 and Lifeline Australia's telephone number are listed on the homepage²⁸⁴. Currently there are 10 people on the committee²⁸⁵. Roles include a Chairperson, Coordinator, Treasurer, Secretary, and general members²⁸⁶. The committee includes employees from South Australian Police as well as people involved in and/or affected by road traffic crashes²⁸⁷. While there is limited staff turnover, the committee is currently establishing job descriptions for each role for succession planning when people leave the service²⁸⁸. The SA Commission of Human Rights acts as an advocate for the service²⁸⁹.

²⁷³ Telephone interview with Heather Grote, Secretary of RTSQ, 13th June 2011

²⁷⁴ <http://www.roadtraumaservicesqld.org/SponsorAAMI.html>

²⁷⁵ <http://www.roadtraumaservicesqld.org/SponsorsGCBF.html>

²⁷⁶ Telephone interview with Heather Grote, Secretary of RTSQ, 13th June 2011

²⁷⁷ <http://www.roadtraumaservicesqld.org/SponsorRhema.html>

²⁷⁸ Telephone interview with Heather Grote, Secretary of RTSQ, 11th April 2011

²⁷⁹ Telephone interview with Heather Grote, Secretary of RTSQ, 11th April 2011

²⁸⁰ <http://www.roadtraumasupportsa.com.au/RSTNewsLetter9.pdf>

²⁸¹ <http://www.roadtraumasupportsa.com.au/RTSTNewsLetter052007.pdf>

²⁸² <http://www.roadtraumasupportsa.com.au/newsletter.html>

²⁸³ <http://www.roadtraumasupportsa.com.au/links.html>

²⁸⁴ <http://www.roadtraumasupportsa.com.au/>

²⁸⁵ <http://www.roadtraumasupportsa.com.au/RTSTNEWSLETTERSspring2010.pdf>

²⁸⁶ <http://www.roadtraumasupportsa.com.au/RSTNewsLetter9.pdf>

²⁸⁷ Face-to-face interview with Sharon Neville, Secretary and Treasurer, RTSTSA, 8th August 2011

²⁸⁸ Face-to-face interview with Sharon Neville, Secretary and Treasurer, RTSTSA, 8th August 2011

²⁸⁹ Face-to-face interview with Sharon Neville, Secretary and Treasurer, RTSTSA, 8th August 2011

The RTSTSA provides support group meetings and referral to counselling²⁹⁰. Counselling is free and there are no charges for other services. The Secretary takes telephone calls to the service. For many callers, the receipt of information about road trauma and the opportunity to speak to someone is enough to help them make sense of their experiences, and help them get back on track²⁹¹. If face-to-face counselling appointments are required, an appointment will be made. The Secretary attempts to 'match' each client to professional counsellor²⁹². Clinical psychologists provide free face-to-face counselling services to individuals and families affected by road trauma²⁹³. The RTSTSA refers to four clinical psychologists in the Adelaide area. Since 2009, a clinical psychologist trained in dealing with children and teenagers had been available for referrals²⁹⁴. There are two psychologists available for the southeast and another for the peninsula area of the state²⁹⁵. The psychologists' fees are reimbursed by the service and generally the service funds four to six sessions²⁹⁶. Additionally, a social worker is available to help clients with paperwork and financial problems²⁹⁷. The social worker is available for home visits²⁹⁸. The RTSTSA does not provide telephone counselling²⁹⁹; however, telephone counselling is arranged if the client's geographical isolation is a problem³⁰⁰.

The RTSTSA offers a monthly support group for bereaved people, primarily bereaved parents, facilitated by a trained volunteer and coordinated by the social worker³⁰¹. The volunteers do not receive formal training but most of them are already members of the emergency services³⁰². Monthly 'Care and Share' meetings have been held for several years³⁰³. The meetings commence at 7pm and occur at the RTSTSA's premises in Adelaide and the meetings are confidential, informal and non-judgmental. Group meetings often include guest speakers from organisations such as Department of the Attorney-General and insurance companies³⁰⁴. Fewer meetings were available in 2010 than in previous years, for reasons described as being beyond the service's control³⁰⁵. A Reflection Night is held annually³⁰⁶. Specific support is offered to drivers and to bereaved people, in recognition of the two groups' specific needs. Drivers may be coming to terms with the injury or death of a person or might be awaiting the outcome of a police investigation and court process. Grieving following bereavement can be a long and isolating journey and griever may benefit from the opportunity to hear others' experiences and contribute their own³⁰⁷.

²⁹⁰ Face-to-face interview with Sharon Neville, Secretary and Treasurer, RTSTSA, 8th August 2011

²⁹¹ <http://www.roadtraumasupportsa.com.au/services.html#counsel>

²⁹² Face-to-face interview with Sharon Neville, Secretary and Treasurer, RTSTSA, 8th August 2011

²⁹³ <http://www.roadtraumasupportsa.com.au/services.html#counsel>

²⁹⁴ <http://www.roadtraumasupportsa.com.au/RTSTnewsletter5.pdf>

²⁹⁵ <http://www.roadtraumasupportsa.com.au/RTSTnewsletter5.pdf>

²⁹⁶ Face-to-face interview with Sharon Neville, Secretary and Treasurer, RTSTSA, 8th August 2011

²⁹⁷ <http://www.roadtraumasupportsa.com.au/RTSTnewsletter9.pdf>

²⁹⁸ Face-to-face interview with Sharon Neville, Secretary and Treasurer, RTSTSA, 8th August 2011

²⁹⁹ <http://www.roadtraumasupportsa.com.au/>

³⁰⁰ Telephone interview with Sharon Neville, Secretary and Treasurer of RTSTSA, 24th May 2011

³⁰¹ Face-to-face interview with Sharon Neville, Secretary and Treasurer, RTSTSA, 8th August 2011

³⁰² Telephone interview with Sharon Neville, Secretary and Treasurer of RTSTSA, 24th May 2011

³⁰³ <http://www.roadtraumasupportsa.com.au/RTSTnewsletter1.pdf>

³⁰⁴ <http://www.roadtraumasupportsa.com.au/RTSTnewsletter4.pdf>

³⁰⁵ <http://www.roadtraumasupportsa.com.au/RTSTNEWSLETTERSpring2010.pdf>

³⁰⁶ <http://www.roadtraumasupportsa.com.au/meetings.html>

³⁰⁷ <http://www.roadtraumasupportsa.com.au/services.html#counsel>

The counselling and support meetings are complemented by informational support. The RTSTSA's website includes information on bereavement, specifically on grief following road trauma, responses to loss, important principles to remember, self-care strategies, and professional counselling,³⁰⁸ as well as trauma from road crashes, common reactions to trauma, and self-care strategies³⁰⁹. Additionally, newsletters are produced on a semi-regular basis and include information about the service and tips for self-help. The current and previous newsletters are available to download from the website³¹⁰.

In addition to the website, the RTSTSA promotes itself by attending Police Expos and rural shows³¹¹, the Australian College of Ambulance Professionals conference³¹², providing seminars to hospital and community groups³¹³, as well as being involved in road trauma education programmes in secondary schools run by South Australian Police's Major Crash section³¹⁴. The service was featured on Channel 7's *Today Tonight* programme in 2006³¹⁵. People are often referred to the RTSTSA via individual police officers and police stations and changes in police staffing often results in a reduction of referrals to the service³¹⁶. The Police, Ambulance, and Fire and Emergency organisations all carry cards and brochures of the service and disseminate these at road trauma scenes. This process has been successful and has the full support of these organisations³¹⁷. The RTSTSA provides teddy bears (called The Ella Bear) to Major Crash officers who give the bears to children in families with a road traffic fatality³¹⁸.

Since 2007, the RTSTSA has been providing services to country areas such as Port Pirie, Port Augusta³¹⁹, and Mt Gambier³²⁰. Country branches in Mt Gambier and Naracoorte are run from community halls on a needs basis and are operated by police officers in those areas. They run bi-monthly to monthly group meetings depending on the requirements at the time³²¹. Due to increasing demand for services, the RTSTSA has embarked on fundraising efforts to complement donations received from Victims of Crime, a section of the Government of South Australia³²². Membership to the RTSTSA is free; members' details are kept confidential and are only used in the dissemination of newsletters and other relevant information³²³.

³⁰⁸ <http://www.roadtraumasupportsa.com.au/grief.html#grief>

³⁰⁹ <http://www.roadtraumasupportsa.com.au/trauma.html#trauma>

³¹⁰ <http://www.roadtraumasupportsa.com.au/newsletter.html>

³¹¹ http://www.roadtraumasupportsa.com.au/news_letterjan_08.pdf

³¹² <http://www.roadtraumasupportsa.com.au/RTSTnewsletter3.pdf>

³¹³ <http://www.roadtraumasupportsa.com.au/RTSTnewsletter3.pdf>

³¹⁴ <http://www.roadtraumasupportsa.com.au/RTSTnewsletter052007.pdf>

³¹⁵ <http://www.roadtraumasupportsa.com.au/RTSTnewsletter2.pdf>

³¹⁶ <http://www.roadtraumasupportsa.com.au/RTSTnewsletter052007.pdf>

³¹⁷ Telephone interview with Sharon Neville, Secretary and Treasurer of RTSTSA, 24th May 2011

³¹⁸ Telephone interview with Kylie Simpson, Senior Constable and Victim Contact Officer, Major Crash, and committee member of RTSTSA, 8th August 2011

³¹⁹ <http://www.roadtraumasupportsa.com.au/RTSTnewsletter052007.pdf>

³²⁰ http://www.roadtraumasupportsa.com.au/news_letterjan_08.pdf

³²¹ Telephone interview with Sharon Neville, Secretary and Treasurer of RTSTSA, 24th May 2011

³²² <http://www.roadtraumasupportsa.com.au/RTSTNEWSLETTERSpring2010.pdf>

³²³ <http://www.roadtraumasupportsa.com.au/membership.html>

The RTSTSA is a non-profit charity and donations to the service are tax deductible. The service has recently embarked on fundraising in partnership with local funeral companies. The Department of the Attorney-General provides an annual grant of \$77,000 per year, indexed according to the CPI. This grant is supplemented by fundraising. Much of this money goes to reimbursing the professionals – the psychologists are paid \$156 per hour and the social worker is paid \$90 per hour – and there are approximately 90 counselling clients per year³²⁴. As such, the RTSTSA has recently commenced referring clients to a grief and loss service at Anglicare (\$50 a session) and is investigating referral to professionals with Medicare numbers so as to only pay the gap³²⁵. The RTSTSA does not fund professional development opportunities for the counselling staff. Contracts with the psychologists and social worker tend range from one to three years and it is expected that they maintain their continuing professional development³²⁶.

The RTSTSA maintains a client contact list for dissemination of newsletters, information on the Reflection Night, sausage sizzle fundraising events, and so on³²⁷. While the service does not engage in formal evaluation, due to resources limitations, it does conduct client satisfaction surveys from time to time³²⁸. Resource limitations are incongruent with the time-intensive paperwork required to maintain their charities licence, prepare financial statements (which are independently audited), and general administration and record-keeping³²⁹. The RTSTSA would like to be involved in research, education, and advocacy but cannot due to funding restrictions and limited staffing resources³³⁰.

Road Trauma Support Tasmania

Formerly the Road Trauma Support Team Tasmania, the service changed its name in July 2011 to Road Trauma Support Tasmania (RTST)³³¹. The service provides a free confidential support and counselling service for people affected by road trauma. The RTST commenced in Launceston in 1989 because of a perceived gap in the support available to those affected by road trauma. Colleen Hall, who had experienced the loss of a number of family members due to road accidents, and who understood the need for support and assistance following such trauma and loss, established the service³³². A volunteer committee manages the organisation and comprises people who recognise the need for such a service and acknowledge the value of the support; some committee members have training and expertise in grief and trauma³³³. The committee consists of a President, Vice-President, Treasurer, and Secretary and the organisation has a Patron (Kerry Finch, MLC)³³⁴. The RTST is the inspiration for the road trauma support services in Victoria, South Australia, and Queensland. Although each of the existing services is different in structure, all have as their

³²⁴ Telephone interview with Sharon Neville, Secretary and Treasurer of RTSTSA, 24th May 2011

³²⁵ Telephone interview with Sharon Neville, Secretary and Treasurer of RTSTSA, 24th May 2011

³²⁶ Face-to-face interview with Sharon Neville, Secretary and Treasurer, RTSTSA, 8th August 2011

³²⁷ Face-to-face interview with Sharon Neville, Secretary and Treasurer, RTSTSA, 8th August 2011

³²⁸ Face-to-face interview with Sharon Neville, Secretary and Treasurer, RTSTSA, 8th August 2011

³²⁹ Face-to-face interview with Sharon Neville, Secretary and Treasurer, RTSTSA, 8th August 2011

³³⁰ Face-to-face interview with Sharon Neville, Secretary and Treasurer, RTSTSA, 8th August 2011

³³¹ Face-to-face interview with Graeme Lunson, Executive Officer of RTST, 13th July 2011

³³² Jeavons (1997)

³³³ <http://www.roadtraumasupport.org.au/about/about.php>

³³⁴ <http://www.roadtraumasupport.org.au/about/about.php>

primary goal the support of those affected by road trauma. In 1994, the RTST was awarded an *Advance Australia Award for Community Service*³³⁵.

The RTST is based at Launceston General Hospital and the Department of Health and Human Services provides the office space and pays for the computer and landline telephone³³⁶. People may call the office number during office hours or call and text the mobile telephone number (available on the website) after hours³³⁷. The Executive Officer of the organisation carries the mobile and he is the only person in the organisation to receive a salary³³⁸. The service was expanded to the northwest coast with the availability of an on-call counsellor in this area³³⁹. Initially, the RTST services were dependent upon donations and fundraising. In 1997, the service ran out of money for six months but has received annual funding since 2001 from the Motor Accident Insurance Board (MAIB), a Government of Tasmania enterprise operating a compulsory third party personal insurance scheme³⁴⁰. The MAIB currently provides the bulk of funding to the RTST; this funding is used to pay counsellors and the Executive Officer and provide their professional indemnity insurance³⁴¹. The MAIB provides \$121,000 for the 2011-2012 year to the RTST³⁴²; this is up 3% on the previous financial year³⁴³. The service is required by the MAIB to produce six-monthly audited statements of expenditure. Although the RTST receives funding and support from the government it is independent from it. The service was described by its President as being “run on a shoestring”, the reimbursement fee to counsellors is small, and that initiatives requiring extra costs are more difficult to fund, including travel to regional areas, which is often funded by donations to the service³⁴⁴.

Support and counselling are available to anyone affected by road trauma. The counselling provided is free and confidential and available during office hours and after hours³⁴⁵. People can telephone a landline or a mobile number. The RTST will take the person’s telephone number and call them back to minimise personal costs³⁴⁶. Counselling can occur over the telephone or face-to-face³⁴⁷. Some counselling occurs at the office but these premises are not ideal as there are steps up to the office, no windows, and the office is located near the mortuary. However, the Launceston Hospitals is currently undergoing refurbishment and the RTST will have access to dedicated counselling rooms in the near future³⁴⁸. The counsellors rarely do home visits and only do so if the client cannot leave his or her home (e.g., agoraphobia); in such an instance, two counsellors will go together for their own safety³⁴⁹.

³³⁵ Jeavons (1997)

³³⁶ Telephone interview with Graeme Lunson, Executive Officer of RTST, 7th June 2011

³³⁷ <http://www.roadtraumasupport.org.au/index.php>

³³⁸ Telephone interview with Graeme Lunson, Executive Officer of RTST, 7th June 2011

³³⁹ Newsletter December 2008 available from <http://www.roadtraumasupport.org.au/news/news.php>

³⁴⁰ Face-to-face interview with Patricia (Pat) Igoe, Counsellor and Committee Member, RTST, 13th July 2011

³⁴¹ <http://www.roadtraumasupport.org.au/about/about.php>

³⁴² Telephone interview with Graeme Lunson, Executive Officer of RTST, 7th June 2011

³⁴³ Face-to-face interview with Graeme Lunson, Executive Officer of RTST, 13th July 2011

³⁴⁴ Face-to-face interview with Robin Ikin, President of RTST, 13th July 2011

³⁴⁵ <http://www.roadtraumasupport.org.au/services/services.php>

³⁴⁶ <http://www.roadtraumasupport.org.au/services/services.php>

³⁴⁷ <http://www.roadtraumasupport.org.au/services/counselling/counselling.php>

³⁴⁸ Face-to-face interview with Patricia (Pat) Igoe, Counsellor and Committee Member, RTST, 13th July 2011

³⁴⁹ Face-to-face interview with Graeme Lunson, Executive Officer of RTST, 13th July 2011

The counsellors listen, provide support strategies, and provide information about other relevant services where appropriate³⁵⁰. During 2008, the RTST provided counselling services to over 200 people, some on several occasions, as well as non-counselling support to many people³⁵¹. As of 2008, three counsellors were available – one each in the north, south, and northwest of Tasmania³⁵². One of these retired from the service in 2009³⁵³ and was replaced. One counsellor (a psychiatric nurse) is employed by a hospital and the remaining two are subcontracted as required³⁵⁴. All three have trauma and grief training³⁵⁵. Some clients utilise the RTST in conjunction with visits to their general practitioner and/or other health professional. The RTST provides services to all parties involved in a collision but will usually use different counsellors for victims and offenders to maintain confidentiality and trust³⁵⁶. The RTST has also produced a brochure outlining their services and a booklet called, *Road trauma support booklet: An information booklet for people who have been affected by road accidents*. The RTST no longer provides peer support because of the resources required to train and supervise the volunteers and match them with clients³⁵⁷.

In the Launceston area, approximately 60% of clients to the RTST come from the Launceston Hospital and the remaining 40% come from the MAIB and Police³⁵⁸. In the Hobart area, approximately half of all referrals are from police and emergency services and the remaining half are from hospitals, MAIB, and other services³⁵⁹. The RTST has provided telephone counselling to people from WA who discovered the service by searching on the internet for assistance³⁶⁰ and to people affected by light plane crashes, tractor crashes on farms and so on because of their similarities to road trauma³⁶¹. The website includes information on trauma³⁶² and grief³⁶³. Only one newsletter is included and it is from December 2008. Regular support groups are not offered but can be requested. For example, the RTST provided support session to a group of young people when a friend was killed by a drunk driver³⁶⁴.

The RTST provides non-counselling support such as assistance in completing MAIB insurance forms, the provision of a support person during an interview (e.g., police or legal) in the aftermath of a road traffic crash or to court, making enquiries on behalf of clients (with their consent), and assisting with enquiries or arrangements about vehicles following crashes³⁶⁵. The RTST also holds an annual non-denominational memorial service as a public acknowledgement of everyone who is affected by road trauma – those who have lost their

³⁵⁰ <http://www.roadtraumasupport.org.au/services/services.php>

³⁵¹ Newsletter December 2008 available from <http://www.roadtraumasupport.org.au/news/news.php>

³⁵² Newsletter December 2008 available from <http://www.roadtraumasupport.org.au/news/news.php>

³⁵³ <http://www.roadtraumasupport.org.au/news/news.php>

³⁵⁴ Telephone interview with Graeme Lunson, Executive Officer of RTST, 7th June 2011

³⁵⁵ Telephone interview with Graeme Lunson, Executive Officer of RTST, 7th June 2011

³⁵⁶ Face-to-face interview with Pat Igoe, Counsellor and Committee Member, RTST, 13th July 2011

³⁵⁷ Face-to-face interview with Pat Igoe, Counsellor and Committee Member, RTST, 13th July 2011

³⁵⁸ Telephone interview with Graeme Lunson, Executive Officer of RTST, 7th June 2011

³⁵⁹ Telephone interview with Graeme Lunson, Executive Officer of RTST, 7th June 2011

³⁶⁰ Telephone interview with Graeme Lunson, Executive Officer of RTST, 7th June 2011

³⁶¹ Face-to-face interview with Graeme Lunson, Executive Officer of RTST, 13th July 2011

³⁶² <http://www.roadtraumasupport.org.au/services/trauma/trauma.php>

³⁶³ <http://www.roadtraumasupport.org.au/services/grieving/grieving.php>

³⁶⁴ Telephone interview with Graeme Lunson, Executive Officer of RTST, 7th June 2011

³⁶⁵ <http://www.roadtraumasupport.org.au/support/support.php>

lives, their families and friends, professionals who assist after road trauma events, those who are injured, and their carers³⁶⁶. These memorials services have been going for the last nine years. Initially, they were held prior to Easter but now occur in November to coincide with World Day of Remembrance for Road Traffic Victims³⁶⁷. From time to time, the service provides education sessions (e.g., talking to nurses about grief, including road trauma) as well as one-off debriefing of groups (e.g., families, workplaces, communities, and so on)³⁶⁸. Counsellors also participant in the Rotary Youth Driver Awareness (RYDA) seminars offered to year 10 students to assist the students if they leave the room due to the content³⁶⁹, have facilitated the contact between the producers of a television programme on road trauma and people affected by road trauma who appeared on the programme³⁷⁰, have been involved with the production and dissemination of road trauma education materials authored by others³⁷¹, and have delivered conference papers (e.g., Critical Incidence Stress Association).

In the last few years, the RTST has commenced providing community education programmes to secondary students about the long-term consequences of road crashes³⁷². More recently, the RTST has developed ties with the Northwest Regional Hospital at Burnie and the Royal Hobart Hospital³⁷³. The RTST has also provided information sessions to nursing and allied health professionals in Tasmania hospitals³⁷⁴. The service is improving its links with police and emergency services and participating in community events to promote the service and assist people with road trauma issues³⁷⁵. The service is supported by police and emergency services, with personnel carrying cards and the RTST brochure to disseminate to road trauma victims at crash scenes³⁷⁶. The RTST is a member of the Northern Regional Recovery Committee, which consists of state emergence services, police ambulance officers, social workers, Centrelink, housing department, and other relevant emergency personnel³⁷⁷.

The Executive Officer has training in acute stress and PTSD and received professional supervision from the head of the social work department at Launceston's General Hospital. The counsellors have trauma and counselling qualifications. Staff members typically access one professional development event per year and in the past have attended an ASD/PTSD workshop in Sydney auspiced by the Australian Centre for Posttraumatic Mental Health as well as local workshops run by professionals who tour to Tasmania³⁷⁸.

The RTST does not evaluate its services, primarily due to budget constraints, nor does it conduct client satisfaction surveys. Instead, it relies upon feedback and referrals from other

³⁶⁶ <http://www.roadtraumasupport.org.au/memorial/memorial.php>

³⁶⁷ Face-to-face interview with Robin Ikin, President of RTST, 13th July 2011

³⁶⁸ Face-to-face interview with Pat Igoe, Counsellor and Committee Member, RTST, 13th July 2011

³⁶⁹ Face-to-face interview with Graeme Lunson, Executive Officer of RTST, 13th July 2011

³⁷⁰ Face-to-face interview with Robin Ikin, President of RTST, 13th July 2011

³⁷¹ For example, Blaszczyński, Panasetis, and Silove (1998)

³⁷² <http://www.roadtraumasupport.org.au/news/news.php>

³⁷³ Newsletter December 2008 available from <http://www.roadtraumasupport.org.au/news/news.php>

³⁷⁴ Newsletter December 2008 available from <http://www.roadtraumasupport.org.au/news/news.php>

³⁷⁵ Newsletter December 2008 available from <http://www.roadtraumasupport.org.au/news/news.php>

³⁷⁶ Telephone interview with Graeme Lunson, Executive Officer of RTST, 7th June 2011

³⁷⁷ Face-to-face interview with Graeme Lunson, Executive Officer of RTST, 13th July 2011

³⁷⁸ Face-to-face interview with Graeme Lunson, Executive Officer of RTST, 13th July 2011

professionals and organisations as indications of endorsement³⁷⁹. A key concern faced by the organisation is its sustainability in the future. The service experiences difficulty in attracting committee members; most of its members have been involved for many years and several are over retirement age. The service does not seem to have a succession plan to guard the longevity of the service. An additional challenge is the unpredictability of client numbers, which might range from no new referrals for a fortnight and then 15 in one day, and the effect this has on planning, staffing, and resources³⁸⁰.

Enough is Enough

Enough is Enough is an anti-violence movement that was established by Ken Marslew in 2005 after the death of his son Michael in an armed robbery a year earlier³⁸¹. Its mission is to “deliver best-practice support services, without discrimination, to those affected by crime, violence, road trauma and anti-social behavior”³⁸². Enough is Enough has received several awards in crime and violence prevention, community service, and victim awareness³⁸³. Additionally, Ken Marslew was the New South Wales finalist for the Senior Australian of the Year in 2010³⁸⁴. Enough is Enough has six Patrons, including the Governor of New South Wales³⁸⁵. Corporate and government sponsors include New South Wales Health, New South Wales Department of Premier and Cabinet, Road and Traffic Authority New South Wales, Westpac, as well as various local businesses and councils³⁸⁶.

The organisation provides a range of programs and strategies designed for people affected by violence³⁸⁷, including road trauma support services³⁸⁸. The aims of the road trauma support services are to assist people affected by road trauma, advocate for legislative change to reduce the incidence of road trauma, to promote availability of support services to trauma victims, and to provide education programs and initiatives to promote road safety³⁸⁹. Key services are counselling and support at reduced cost as well as education. Each individual face-to-face session (50 minutes) incurs a fee of \$40 while couples counselling incurs a fee of \$60 per 50-minute session³⁹⁰. Telephone counselling incurs a \$15 fee per session and attending a support group meeting costs \$10 per session. The support groups, usually run monthly, are facilitated by a professional counsellor³⁹¹. The counsellors are fully qualified in areas of trauma, grief and loss and belonging to the appropriate professional counselling associations³⁹². Clients tend to find out about the service from police, lawyers, and publicity in the media. The group also organises the International Road Trauma Victims Remembrance Day for both New South Wales and Queensland; these events provide new

³⁷⁹ Face-to-face interview with Graeme Lunson, Executive Officer of RTST, 13th July 2011

³⁸⁰ Face-to-face interview with Robin Ikin, President of RTST, 13th July 2011

³⁸¹ <http://www.enoughisenough.org.au/about/>

³⁸² <http://www.enoughisenough.org.au/about/mission/>

³⁸³ <http://www.enoughisenough.org.au/eieawards/>

³⁸⁴ <http://www.australianoftheyear.org.au/recipients/?m=kenb-marslew-2010>

³⁸⁵ <http://www.enoughisenough.org.au/sponsors/>

³⁸⁶ <http://www.enoughisenough.org.au/sponsors/>

³⁸⁷ <http://www.enoughisenough.org.au/about/services/>

³⁸⁸ <http://www.enoughisenough.org.au/roadtrauma/>

³⁸⁹ <http://www.enoughisenough.org.au/roadtrauma/>

³⁹⁰ <http://www.enoughisenough.org.au/counsellingSydney/#OUR>

³⁹¹ <http://www.enoughisenough.org.au/assets/File/pdf1/RoadTraumaSupport2008Brochure.pdf>

³⁹² <http://www.enoughisenough.org.au/counsellingSydney/>

referrals to the organisation's services³⁹³. Enough is Enough can provide professional support for clients during court cases and conferencing between victim and offenders³⁹⁴. Services are not formally evaluated but testimonials are available³⁹⁵. Currently, Enough is Enough does not keep data on the number of clients, how long they access counselling and support, and where they heard of the service³⁹⁶.

The Enough is Enough website is comprehensive (although some links deliver error messages) and includes links to information brochures on the counselling, support and education options that are available³⁹⁷. The site also links to Enough is Enough YouTube videos (e.g., launches, days of remembrance), media coverage of Enough is Enough³⁹⁸, and a blog³⁹⁹. Enough is Enough has links to Twitter, Facebook and an e-newsletter⁴⁰⁰ and the Lifeline and Parent Line telephone numbers⁴⁰¹.

The service also offers education programmes such as the Road Awareness Programme for secondary school students, which includes 'real-life' accounts of victims and offenders⁴⁰², and the "R" Drivers Awareness Programme for serious and repeat driving offenders. The programme consists of two 90-minute sessions and is presented by a man whose son was killed by a 'hit and run' driver who had been drinking alcohol and speeding⁴⁰³. They also present one week's information in a 7-week course in association with the Police and Citizens Youth Club where a volunteer from Enough is Enough talks about the impact of road trauma on their lives⁴⁰⁴. The Enough is Enough charges \$100 to provide the volunteer presenter for this programme; the charge for the school programme is \$500 plus a \$77 booking fee⁴⁰⁵.

Enough is Enough has five chapters of its Road Trauma Support Network across New South Wales and Queensland, offering some metropolitan and some regional coverage in both states. The head office is in Sutherland (a suburb of Sydney), with additional chapters in Gosford and Grafton (both in New South Wales), and Brisbane and Toowoomba (both in Queensland)⁴⁰⁶. For a fee (see above), telephone counselling is available to those who would be unable to attend face-to-face counselling.

Enough is Enough receives funds from the sale of products⁴⁰⁷, membership fees (ranging from \$5 to \$50), subscription fees (ranging from \$15 to \$100), donations and bequests, and

³⁹³ Telephone interview with Ken Marslew, Enough is Enough, 31st May 2011

³⁹⁴ <http://www.enoughisenough.org.au/assets/File/pdf1/RoadTraumaSupport2008Brochure.pdf>

³⁹⁵ <http://www.enoughisenough.org.au/testimonials/>

³⁹⁶ Telephone interview with Ken Marslew, Enough is Enough, 31st May 2011

³⁹⁷ <http://www.enoughisenough.org.au/Publications/#Currentbrochures>

³⁹⁸ <http://www.enoughisenough.org.au/Publications/#Currentbrochures>

³⁹⁹ <http://www.enoughisenough.org.au/eieblog/>

⁴⁰⁰ <http://www.enoughisenough.org.au/home1/>

⁴⁰¹ <http://www.enoughisenough.org.au/roadtrauma/>

⁴⁰² <http://www.enoughisenough.org.au/roadtrauma/#Education>

⁴⁰³ [http://www.enoughisenough.org.au/assets/File/pdf1/RDriversAwarenessProgrammeBrochure\(1\).pdf](http://www.enoughisenough.org.au/assets/File/pdf1/RDriversAwarenessProgrammeBrochure(1).pdf)

⁴⁰⁴ Telephone interview with Ken Marslew, Enough is Enough, 31st May 2011

⁴⁰⁵ Telephone interview with Lisa O'Grady, Enough is Enough, 20th June 2011

⁴⁰⁶ <http://www.enoughisenough.org.au/assets/File/pdf1/RoadTraumaSupport2008Brochure.pdf>

⁴⁰⁷ <http://www.enoughisenough.org.au/products/>

corporate sponsorship; additionally, people volunteer their time and skills⁴⁰⁸. The State Government of New South Wales provides an annual grant of \$115,000; note this is for the entire organisation, not just for the road trauma services⁴⁰⁹. The annual report/annual income and expenditure figures were requested in May 2011 but were not forthcoming.

No information could be accessed regarding the organisation's annual report, governance and board membership, staff recruitment, establishment costs, income and expenditure, required resources, referral pathways to and from the service, and evaluation of services.

True Light Foundation

Launched in 2008⁴¹⁰ and established by Jennifer (Jenn) Franco who was seriously injured in a road trauma event, The True Light Foundation advocates for the development of better support for surviving victims of road trauma in New South Wales⁴¹¹. Its mission is, "To provide assistance, guidance and advice to innocent victims of road trauma aged between 18 and 35, initially in Sydney's metropolitan area, by providing readily available and accurate information, including pointers to legal and insurance options, respite services, access to emotional, physical and spiritual support for both victims and their families"⁴¹². Its objectives are to secure donations of time, money and services to provide information (including an information pack to help people navigate the health, medical, legal and law enforcement systems); Services (including advocacy and lobbying) to assist with the emotional, mental, physical, spiritual and other help needed by victims immediately following a road trauma; and a purpose-built haven called the TrueLight Centre to enhance the accumulation and dissemination of knowledge, and provide services to victims, their families and dependants⁴¹³.

The True light Foundation promotes itself through its user-friendly website. The foundation is attempting to identify and appoint a suitable Patron⁴¹⁴ and has the support of four Ambassadors, including television and sporting personalities⁴¹⁵. The foundation has 18 sponsors including Telstra, and many small businesses (e.g., a women's health club, a restaurant, a cosmetics company, a private photographer, to name a few)⁴¹⁶. Jenn was a finalist for the Pride of Australia Award, Courage category, in 2007⁴¹⁷.

The Foundation has a committee consisting of a chairman, managing director, operations manager, marketing manager, human resources manager, accountant, human resources officer, events and fundraising officer and two promotions officers – all volunteer their time and skills⁴¹⁸. In October 2010, representatives from the Foundation met with the NSW Motor Accidents Authority to discuss options for the development and dissemination of an

⁴⁰⁸ <http://www.enoughisenough.org.au/help/#Become>

⁴⁰⁹ Telephone interview with Ken Marslew, Enough is Enough, 31st May 2011

⁴¹⁰ <http://www.truelightfoundation.org/docs/MediaRelease08Jul08.pdf>

⁴¹¹ <http://www.truelightfoundation.org/>

⁴¹² <http://www.truelightfoundation.org/VisionMissionAndObjectives.html>

⁴¹³ <http://www.truelightfoundation.org/VisionMissionAndObjectives.html>

⁴¹⁴ <http://www.truelightfoundation.org/OurPatron.html>

⁴¹⁵ <http://www.truelightfoundation.org/OurAmbassadors.html>

⁴¹⁶ <http://www.truelightfoundation.org/OurSponsors.html>

⁴¹⁷ <http://www.truelightfoundation.org/AboutJenn.html>

⁴¹⁸ <http://www.truelightfoundation.org/TheTeam.html>

information pack for victims of road trauma⁴¹⁹. Since February 2011, the Foundation has been focussing on putting together an information package for road trauma survivors⁴²⁰.

The Foundation relies on three sources of income – sponsorships, fundraising events, and donations. Donations can be made to the Foundation via the website⁴²¹. The foundation does not provide any services at this time. As such, referral pathways to and from the foundation and service evaluation data cannot be reported. No information could be found on the foundation's staff training and recruitment, establishment and ongoing costs, and required resources.

Motor Vehicle Fatality Support Program

The Motor Vehicle Fatality Support Program (MVFSPP) delivers immediate and ongoing social support to witnesses and family members affected by a motor vehicle fatality⁴²². The service is underpinned by SupportLink, a private company contracted by Australian Capital Territory (ACT) Police that provides a 24-hour a day, 7-day-a-week on-call referral system between Police and social supports to increase the opportunities for individuals and families in need to receive the appropriate support⁴²³. The MVFSPP provides a single-referral gateway as emergency personnel (e.g., police and ambulance officers) refer all individuals at the site of a road trauma via an e-referral system⁴²⁴. The service is based on the idea that immediate intervention promotes the likelihood of ongoing engagement with support options⁴²⁵. Qualified support workers provide at-the-scene trauma support and follow-up, including assistance with delivering death messages, body identification and family support; follow up support of families and witnesses; and liaison between families, witnesses and Police; and assistance with coronial processes⁴²⁶.

The MVFSPP is beneficial to the ACT Police as it allows police officers to engage in their primary role of investigating collisions; it also enhances the public perception of ACP Police⁴²⁷. The MVFSPP replaced the National Centre for Road Trauma, which aimed to provide support for people affected by road trauma (witnesses, injured, bereaved, their families, and motorists responsible for collisions) in the ACT⁴²⁸. The MVFSPP was established in the ACT in 2008⁴²⁹ and in 2010, SupportLink began trials of an e-referral service with the Queensland and Victorian police⁴³⁰.

The proportion of people who access support following referral, the groups they represent (i.e., witnesses, bereaved, etc.), the services to which they referred, and the costs they incur in accessing the supports to which they are referred, is not known. Additionally, the service

⁴¹⁹ <http://www.truelightfoundation.org/>

⁴²⁰ <http://www.truelightfoundation.org/docs/RecruitmentCampaignInformationPack22Feb11.pdf>

⁴²¹ <http://www.truelightfoundation.org/Donations.html>

⁴²² <http://www.supportlink.com.au/aboutMVFatalitySupport.cfm>

⁴²³ <http://www.supportlink.com.au/history.cfm>

⁴²⁴ <http://www.supportlink.com.au/aboutReferralSystem.cfm>

⁴²⁵ <http://www.supportlink.com.au/aboutMVFatalitySupport.cfm>

⁴²⁶ <http://www.supportlink.com.au/aboutMVFatalitySupport.cfm>

⁴²⁷ <http://www.supportlink.com.au/aboutMVFatalitySupport.cfm>

⁴²⁸ Telephone interview with Heather Muir, National Centre for Road Trauma, 17th May 2011

⁴²⁹ <http://www.supportlink.com.au/aboutMVFatalitySupport.cfm>

⁴³⁰ <http://www.supportlink.com.au/history.cfm>

is linked to fatal crashes, and this means that people who are affected by non-fatal crashes are likely to remain unsupported. Further information was not approved for release to the researchers of this project⁴³¹. As such, this information, as well as service evaluation procedures, cannot be reported.

Trans-Help Foundation

The Trans-Help Foundation was established in 2006 to assist Australian transport personnel and their families with the effects of the transport industry, including injuries and bereavement from road trauma, WorkCover processes, and related issues⁴³². Its mission is to provide “support and assistance to Operators, Drivers and their Families connected with the Transport Industry who are suffering any form of crisis”⁴³³ and it is a non-profit charity⁴³⁴. The foundation is based in New South Wales⁴³⁵.

The service has an informative website that is easy to navigate. Support is provided via the national support telephone line and the mobile health and support unit. The national support line (a 1300 number) is monitored 24 hours 7 days a week and provide supports as well as referral. They also promote themselves via Facebook and Twitter. To 30th December 2010, Trans-Help took 5,986 telephone calls for assistance⁴³⁶. The website also includes links to several brochures including *Coping with grief*, *The grief journey*, *Helping a friend*, *Funeral support*, *Road trauma*, *Depression*, *Panic disorder*, and *Witnessing an accident*⁴³⁷. In partnership with BeyondBlue, Trans-Help produced a book in hard copy and audio formats, called *Taking Care of Yourself and Your Family*. It outlines information on depression, anxiety, disturbing thoughts, recovery from trauma, insomnia, conflict, anger, stress, relationship violence, alcohol, substances and mental health, grief, key services and resources, and guided progressive muscle relaxation⁴³⁸. The mobile health and support unit traverses major transport corridors to provide preventative health checks for drivers and onsite support for drivers suffering road trauma or general depression⁴³⁹.

The foundation has numerous sponsors including multinationals like American Express, various transport companies, and BeyondBlue (the national depression initiative) just to name a few; the type of sponsorship is not available⁴⁴⁰. The website includes links to

⁴³¹ Email from Sarah Young, State Coordinator of SupportLink, to Jenny Clarke, 9th June 2011

⁴³² http://www.transhelpfoundation.com.au/index.php?option=com_content&view=article&id=90:clients-stories&catid=14:article&Itemid=488

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⁴³⁴ http://www.transhelpfoundation.com.au/index.php?option=com_content&view=article&id=106&Itemid=534

⁴³⁵ http://www.transhelpfoundation.com.au/index.php?option=com_content&view=article&id=107&Itemid=535

⁴³⁶ http://www.transhelpfoundation.com.au/index.php?option=com_content&view=article&id=9&Itemid=490

⁴³⁷ http://www.transhelpfoundation.com.au/index.php?option=com_content&view=article&id=114:statistics-call-centre&catid=14:article&Itemid=538

⁴³⁸ http://www.transhelpfoundation.com.au/index.php?option=com_content&view=article&id=114:statistics-call-centre&catid=14:article&Itemid=538

⁴³⁹ http://www.transhelpfoundation.com.au/index.php?option=com_content&view=article&id=113:taking-care-of-yourself-a-family&catid=14:article&Itemid=537

⁴⁴⁰ <http://www.transhelpfoundation.com.au/>

http://www.transhelpfoundation.com.au/index.php?option=com_content&view=article&id=89&Itemid=466

transports services and government departments but does not link to any road trauma support services in Australia⁴⁴¹.

No information could be accessed regarding the organisation's annual report, staff recruitment and training, establishment costs, income and expenditure, required resources, fee structure for services, referral pathways to other services, and evaluation of services.

Conclusion

Road trauma support services are currently operating elsewhere in Australia, each offering various services and with varying governance and budgets. A summary of each service's strengths and limitations is provided in Table 6. The most comprehensive road trauma support service operates in Victoria. The strengths of its Road Trauma Support Services include its freecall telephone number, community-based premises with public transport access, ongoing funding (allowing for future planning), the provision of supervised peer support, engagement in community education, fundraising through educational workshops for offenders, regional service delivery, strong partnerships with relevant organisations, and provision of professional development opportunities to staff. However, it is not a trauma service per se; rather, it provides supportive counselling and associated services to people affected by road trauma. This is because the Transport Accident Commission pays families up to \$5,580 to cover the costs of medical, psychological, and rehabilitative services following involvement in a road traffic crash⁴⁴². Furthermore, it does not provide any services for children and adolescents and it struggles with attraction and retention of staff due to low wages and cannot advertise its services as it would be unable to cope with an increase in service demand.

The Road Trauma Support Tasmania offers state-wide services, has a dedicated committee, well-established links with hospitals and emergency service personnel, and does focus on trauma intervention, including for children and adolescents. However, it struggles with the issue of succession planning and attraction of staff and does not provide peer support due to resource limitations.

The Road Trauma Support Team of South Australia combines referral of clients to professional psychologists and social workers, and paying the fees on behalf of clients, with the provision of monthly support groups. Strengths include this combination of services, the freecall telephone number, links with relevant organisations, regional services, the community-based premises, services for children, and a committee dedicated to road trauma issues. Despite a greater population, it has smaller budget than Road Trauma Support Tasmania and its ability to expand is restricted by financial limitations. Additionally, its premises are small and difficult to find from the road.

⁴⁴¹ http://www.transhelpfoundation.com.au/index.php?option=com_content&view=article&id=115:transport-a-associated-links&catid=14:article&Itemid=539

⁴⁴² <http://www.tac.vic.gov.au/jsp/content/NavigationController.do?areaID=26&tierID=2&navID=D9AB31F77F00000100BCE28A1516A0B2&navLink=null&pageID=587>

Table 6

A Summary of Each Service's Strengths and Limitations

<i>Service</i>	<i>Strengths</i>	<i>Limitations</i>
Road Trauma Support Services (Victoria)	Freecall telephone; free counselling; community-based premises with public transport access; ongoing government funding; supervised peer support; community education; fundraising through offender workshops; state-wide; links with other services; training for staff; non-profit	Not a trauma service; no services to children and adolescents; struggles to attract and retain staff due to low wages
Road Trauma Services Queensland	Freecall telephone; free counselling; community education; non-profit	Limited resources; no government funding; no premises; not state-wide
Road Trauma Support Team of South Australia	Freecall telephone; state-wide; links with other services; community-based premises with public transport access; services for children and adolescents; monthly support groups; referral/coordination service; 4-6 free sessions; non-profit	Small budget; premises are small and difficult to find from the road
Road Trauma Support Tasmania	Trauma focus; services for children and adolescents; links with relevant services; state-wide; non-profit	No peer support/volunteers; hospital setting; struggles to attract staff; no succession planning
Enough is Enough	Counselling; community education; advocacy	Fees are charged irrespective of client income
True Light Foundation	Advocacy	No client services; seems defunct
Motor Vehicle Fatality Support Program	Free referral service	Support services are not free; part of a private (for profit) company
Trans-Help Foundation	National telephone information and support; non-profit	Specific to transport personnel and their families

The following services are not comprehensive road trauma support services. The Road Trauma Services Queensland manages to provide some support on very limited resources but, due to a lack of funding, is neither state-wide nor able to provide comprehensive services. In New South Wales, road trauma support services are housed within Enough is Enough's comprehensive anti-violence movement and these services are combined with road trauma community education and advocacy. However, fees are charged for client services, irrespective of income. The True Light Foundation does not provide client services. In the Australian Capital Territory, the Motor Vehicle Fatality Support Program provides a referral service for people affected by road crashes, primarily those involved at road crash scenes. The referral service is free but the support services to which clients are referred are not. Finally, the TransHelp Foundation, based in New South Wales, aims to provide Australia-wide services specific to transport personnel and their families.

8.0 RECOMMENDATIONS

This report has outlined the psychosocial and economic consequences of road traffic crashes, with particular emphases on people bereaved by road traffic crash fatalities; people injured in road traffic crashes; families, friends, and unpaid carers of those who are injured; witnesses of and first responders to road traffic crashes; and offenders/others involved in road traffic crashes without charge and their families. However, despite the psychosocial and economic consequences of road traffic crashes, there are considerable service delivery gaps in existing arrangements in WA.

No dedicated road trauma support service currently operates in WA. Existing government services are severely stretched. Time delays in accessing services, the limited availability of suitable services, service costs, and a lack of long term support can lead to victims and their families feeling unsupported and isolated. Failure to address these issues can hinder an individual's ability to optimise their family, vocational and social functioning following a serious crash. Road trauma support services exist in all other Australian states and they vary in terms of funding levels and sources, governance, types of services they offer, the extent to which their services are state-wide, and costs to users.

We propose 22 recommendations for the development and operation of a comprehensive road trauma support service in WA. These are presented below, under the 12-point outline of required work as required by the Department of Health (WA) in the "Contract to Investigate Mechanisms and Costs Associated with Establishing a Sustainable Road Trauma Support Service in Western Australia." The recommendations are provisional rather than definite in nature, allowing further details to be developed by the Implementation Steering Group when the road trauma support service is established (see Recommendation 19).

- **Point 1: Recommended road trauma support roles and services and evidence supporting their effectiveness (including a review of interstate road trauma support services).**

Reviews of intervention efficacy for trauma and bereavement and interstate road trauma support services are provided in earlier sections of this report (see Sections 5 and 7 respectively). These reviews underpin the recommendations discussed below outlining the establishment of a sustainable road trauma support service in and for WA.

- **Point 2: Preferred options and recommendations to establish sustainable road trauma support service in WA, including possible service providers.**

Recommendation 1

A road trauma support service be established for WA

A road trauma support service in WA is required to provide sustainable peer support and professional therapeutic interventions for road trauma victims, family members, offenders, witnesses, and for others who are adversely affected by road trauma. The service would be the peak body for road trauma issues in WA and would help to prevent and minimise future functional impairments that may be caused by bereavement and exposure to trauma. A comprehensive support service would legitimise the needs of people affected by road traffic

crashes. Additionally, it would be of political and symbolic importance, both in terms of recognising the needs of people affected by road traffic crashes and also in aligning with state and national commitments to promote the road safety message^{443,444}. The establishment of a road trauma support service for WA is supported by the RAC(WA)⁴⁴⁵, WA politicians⁴⁴⁶, WA Police⁴⁴⁷, and others in WA, as well as existing road trauma support services interstate⁴⁴⁸. An expression of interest (EOI) process may be followed to establish the organisation in line with the recommendations herein.

Recommendation 2

The road trauma support service be funded by the Government of WA

The Government of WA's Road Trauma Trust Account is the most obvious source of recurrent funding for the road trauma support service. From 1st July 2011, two-thirds of red light and Multanova revenue will go to the Government of WA's Road Trauma Trust Account. Furthermore, the Road Trauma Trust Fund will receive 100% of the revenue from 1st July 2012^{449,450}. The use of Road Trauma Trust Fund monies for a road trauma support service has also received bipartisan support from WA politicians^{451,452,453,454}. It is worth noting that funding has previously been sought from and rejected by various sources including the RAC(WA)⁴⁵⁵, which did not offer a reason, and the Insurance Commission of WA⁴⁵⁶; the latter is predicated on the *Insurance Commission of Western Australia Act*, which precludes the Commission from funding the service. The RAC(WA) recommends that Government of WA commits \$1million per year to fund the service⁴⁵⁷. The figure, while not fully-costed, is an estimation based on the Road Trauma Support Services Victoria annual budget plus establishment costs.

If funding from the Road Trauma Trust Account does not occur, the service could attain recurrent funding from the Department of Health (WA). Again, if this does not occur, a mix

⁴⁴³ Office of Road Safety (2009)

⁴⁴⁴ Australian Transport Council (2011)

⁴⁴⁵ RAC State Budget Submission 2010/2011

⁴⁴⁶ Rob Johnson (MLA, Minister for Police; Emergency Services; Road Safety, Leader of the House and Member for Hillarys) and John Quigley (MLA, Shadow Attorney-General and Member for Mindarie), *Hansard* 24th September 2009.

⁴⁴⁷ Telephone interview with Acting Inspector Gary Nicholau, Major Crash, WA Police, 17th August 2011

⁴⁴⁸ Interviews with staff at the Road Trauma Support Services Victoria, 12th July 2011; Interviews with staff at Road Trauma Support Tasmania, 13th July 2011; Interviews with staff at the Road Trauma Support Service South Australia, 8th August 2011.

⁴⁴⁹ Big win for road safety (2011)

⁴⁵⁰ Road Safety Council Act 2002 (as at 17th August 2011)

⁴⁵¹ Email from Terry Redman, MLA and Minister for Agriculture and Food; Forestry; Corrective Services, to Glenda Maloney, Australian Parents Against Road Trauma, 27th June 2011

⁴⁵² Rob Johnson MLA and Minister for Police; Emergency Services; Road Safety, *Perth Now* 23rd June 2011 <http://www.perthnow.com.au/news/western-australia/road-trauma-bill-in-bad-taste-says-victim/story-e6frg14c-1226080894166>

⁴⁵³ Media release from Margaret Quirk, MLA and Shadow Minister for Police; Emergency Services; Road Safety, 23rd June 2011

⁴⁵⁴ Letter from Hon Colin Barnett, MLA and Premier of Western Australia, to Alan and Glenda Maloney, 11th June 2011

⁴⁵⁵ Letter from Devika Tampi, Sponsorship Officer, RAC(WA), to Glenda and Alan Maloney, 8th September 2008

⁴⁵⁶ Letter from Ken McAullay, Acting Managing Director, Insurance Commission of WA, to Alan and Glenda Maloney, 13th January 2010

⁴⁵⁷ RAC State Budget Submission 2010/2011

of funding could be sought. For instance, the Department of Health (WA) and the Disability Services Commission could provide some recurrent funding; the Royalties for Regions scheme could provide a one-off grant to meet the costs associated with establishing infrastructure and services in rural, regional, and remote WA; and funding could also be sought from private businesses and major industries (e.g., mining and resources), and consortia (e.g., the Industry Road Safety Alliance that exists in the Collie and Boddington areas⁴⁵⁸). However, a mixed-funding model is fragmented, complex, and requires the breaking-down of cross-sector silos to work. A final possibility is the establishment of a separate Government fund specifically for funding the service.

Ideally, the service would be fully-funded from the Government of WA yet independent from the funding source(s). The relationship between the road trauma support service and the Government of WA should be underpinned by a memorandum of understanding in order to articulate a common understanding of the roles and expectations of each party. Suggestions regarding the monitoring of the service are provided in Recommendation 18. However, if this is not possible, naming rights could be discussed as a way to get funding/sponsorship if the budget will not be serviced by the Government of WA; however, this is not the preferred option. In terms of economic sustainability of the service delivery, suggestions for partial cost-recovery are described in Recommendation 7.

- **Point 3: Options to facilitate the delivery of accessible peer support and professional counselling across metropolitan and regional WA.**

Recommendation 3

The road trauma support service be a comprehensive ‘one-stop shop’ and provide services on a state-wide basis

The road trauma support service should be a comprehensive, ‘one-stop shop’ for all people affected by road traffic crashes (and related transport trauma). A dedicated and state-wide road trauma support service that offers information, education, support, and intervention, would enable service providers to have a place to refer people to for support and coordination, rather than the “circle of referral”⁴⁵⁹ that exists currently. Given that approximately 50 to 60% of all road traffic crashes, fatalities, and serious injuries occur outside the Perth metropolitan area⁴⁶⁰, and that a single serious road traffic crash may affect an entire rural community⁴⁶¹, it is clear that the service must service all of WA. The service should be based in Perth with trained peer supporters in several regional areas of WA. Telephone and information and communication technologies may be used, especially to service clients who do not have access to local service providers. There are three online modes of service delivery – web-based information and psychoeducation, self-guided web-based therapy, and therapist-supported web-based therapy⁴⁶². Research has shown that interventions using these technologies are just as effective as face-to-face therapeutic interventions for people who are unable to access more ‘traditional’ forms of

⁴⁵⁸ <http://www.roadwise.asn.au/groups/southwest/industrysalliance>

⁴⁵⁹ Breen (2007, p. 164)

⁴⁶⁰ <http://www.ors.wa.gov.au/Statistics.aspx>

⁴⁶¹ Willis, Cameron, and Igoe (1997)

⁴⁶² Barak, Klein, and Proudfoot (2009)

intervention^{463,464} as well as people who prefer that the online mode offers reduced emotional exposure (i.e., can be used for people in the metropolitan area, too)⁴⁶⁵. These technologies may be synchronous (e.g., Internet video conferencing, Skype, and so on) or asynchronous (e.g., via email) but users require training to use these technologies competently and ethically⁴⁶⁶.

- **Point 4: Recommended mechanism to advertise and to promote road safety peer support services state-wide.**

Recommendation 4

The service's peer support services be advertised and promoted on a state-wide basis

The ability of the service to advertise and promote peer support services is predicated on having a dedicated, full-time Volunteer Coordinator (see Recommendation 14). This role will entail recruiting, training, and supervising the peer support volunteers, on a state-wide basis, particularly in major towns. The recruitment and training of these volunteers will be supported by the strong partnerships between the service and other organisations (e.g., WA Police, Office of the Coroner and its Coronial Counselling Service, Victim Support Service) as described in Recommendation 20.

- **Point 5: The scope, extent and duration of cost-free support for victims, offenders, witnesses, family and friends and other community members.**

Recommendation 5

The road trauma support service be delivered according to service need

The road trauma support services should be provided according to individual need rather than applied universally. Population estimates for the three components of support are presented in Table 7. If there are approximately 200 fatalities per year in WA and each fatality significantly affects 13 people⁴⁶⁷, in any year, 2,600 Western Australians would require information and compassion, 867 would require non-specialist support, and 260-520 would require professional psychotherapeutic interventions. Note that some clients might require one or more components for longer than one year.

It is more difficult to estimate populations in need of the three components following non-fatal road traffic crashes; trauma responses are not related to the objective severity of the crash or the presence of physical injury⁴⁶⁸, and the proportions of people requiring the different components of care are yet to be established. However, if we conservatively assume two people are significantly affected per serious injury, and there are 2,800 serious injuries per year in WA⁴⁶⁹, in any year, 5,600 Western Australians would require information and compassion. If we assume the proportions of people with greater need are the same as for the bereaved, there would be 1,867 people requiring non-specialist supports and 560-

⁴⁶³ Kiropoulos et al. (2008)

⁴⁶⁴ Barak, Hen, Boniel-Nissim, and Shapira (2008)

⁴⁶⁵ King, Bambling, Reid, and Thomas (2006)

⁴⁶⁶ Shandley, Klein, Kyrios, Austin, Ciechowski, and Murray (2011)

⁴⁶⁷ Hayward (1998)

⁴⁶⁸ Blanchard and Hickling (2004)

⁴⁶⁹ <http://www.ors.wa.gov.au/TopicsRoadSafety/Pages/SeriousInjuries.aspx>

1,120 requiring professional psychotherapeutic interventions. Again, note that some services might be required by some clients for longer than one year. Taken together, conservative annual population estimates for each component of care following road trauma events are presented in the right hand side column.

Table 7

Annual Population Estimates Requiring the Three Components of Support following Road Traffic Crash Fatalities and Serious Injuries in WA

Type of Support	Target Population	Population Estimates		Total
		Fatalities	Serious Injuries	
1 Information and compassion	All affected (100%)	2,600	5,600	8,200
2 Non-specialist support (e.g., peers, mutual-help groups, counsellors)	Those at-risk of developing complex needs (33%)	867	1,867	2,734
3 Professional psychotherapeutic interventions (e.g., psychologists)	Those with complex needs (10-20%)	260-520	560-1,120	780-1,640

Note: Population estimates for non-specialist support and professional psychotherapeutic interventions are not known so we have assumed they are the same as for the bereaved group.

The identification of people in need of support services/'at-risk' without intervention is of utmost importance, for service efficacy as well as economic reasons. We recommend that screening, assessment, intervention, and monitoring follow the practice guidelines published by the Australian Centre for Posttraumatic Mental Health⁴⁷⁰. Research shows that people meeting the criteria for traumatic grief are significantly less likely to seek medical help for physical health issues and no more likely to seek help from mental health professionals for psychological difficulties, than people who did not satisfy the criteria for traumatic grief⁴⁷¹. Therefore, adequate promotion of the service and outreach is required to get at the populations in need (see direct client services in the community counselling model in Table 8, Recommendation 10).

Recommendation 6

The road trauma support service be provided with no charge to clients

The cost of mental health services can be considerable. The costs of funerals can be difficult to meet, especially for people who are ineligible for reimbursement through the Fatal Accidents Act, and families might also be dealing with a loss of income. As a result, the information and compassion component would be provided free to all, regardless of income. This component of service delivery includes a toll-free, state-wide telephone number,

⁴⁷⁰ Australian Centre for Posttraumatic Mental Health (2007)

⁴⁷¹ Prigerson et al. (2001)

information on the website, and information packs for families, bereaved, injured, and others affected by road traffic crashes. Similarly, the non-specialists support (e.g., peer support, mutual-help groups, general counselling) would also be provided at no charge.

In terms of the specialist intervention, the Federal Government's Better Access program provides up to six Medicare-subsidised allied mental health services per calendar year, with an additional four available to patients who require additional assistance⁴⁷². In the majority of instances, clients pay a considerable gap per session⁴⁷³. The road trauma support service's specialist professional interventions would also be free. Charging fees according to a 'pay-as-you-earn' scale⁴⁷⁴ was discussed at the third stakeholder reference group meeting but not supported as it was considered impractical, unnecessarily intrusive, and not particularly effective as cost-recovery strategy. Additionally, almost all other road trauma services do not charge any fees. For example, the Road Trauma Support Services (Victoria) does not charge fees as it does not consider it appropriate to means-test a traumatised clientele⁴⁷⁵.

Recommendation 7

The road trauma support service provides preventative education services

These preventative education services would not overlap with the Office of Road Safety's crash prevention public education campaigns but, by focussing on post-crash consequences and supports, would complement them. Additionally, the provision of preventative education workshops would be a viable cost-recovery option (as is the case for the RTSSV). These workshops could be provided to three key groups – road traffic offenders (e.g., pay a fine or pay to attend an education session/workshop to have a driver's licence reinstated), profit-based organisations (e.g., businesses), and professionals (e.g., *Working with Clients Bereaved through Road Traffic Crashes*, *Working with People affected by Road Trauma*, for psychologists, social workers, and other health professionals). Some road trauma organisations run these sessions (e.g., RTSSV, which raises approximately one-third of its income with education sessions for offenders), as do other groups such as ARBOR (Active Response Bereavement OutReach) in order to raise funds for service delivery. It would be beneficial for these workshops aimed at professionals to have professional development points auspiced by professional bodies. It should be noted, however, that community groups and other non-profit organisations would not be charged a fee for this service.

- **Point 6: Criteria for selecting, training and appointing professional and peer support counsellors as required.**

Recommendation 8

The road trauma support service links with appropriately-trained trauma and bereavement therapists to provide professional psychotherapeutic interventions

Professional psychotherapeutic interventions (e.g., mental health services, specialist psychotherapy, and bereavement and trauma services) and non-specialist supports are required by those with, and at-risk of developing, complex needs (totalling about one-third of the population affected by fatal crashes). However, studies have shown that counsellors

⁴⁷² <http://www.medicareaustralia.gov.au/provider/budget-2011/NMHR-better-access-initiative.jsp>

⁴⁷³ Pirkis et al. (2011)

⁴⁷⁴ Australian Bureau of Statistics (2009)

⁴⁷⁵ Face-to-face interview with John Downes, Manager of Support Services, RTSSV, 12th July 2011

experience significantly higher levels of discomfort and display low empathy in dealing with death and dying when compared to other potentially sensitive issues^{476,477}. As such, mental health professionals employed within the road trauma support service require appropriate qualifications, experience, and continuing professional development opportunities in the areas of trauma, loss, bereavement, and family systems. Given the notion that the service pays the fee gaps for eligible clients (see Recommendation 6), it is recommended that the therapists have Medicare provider numbers. Many serious road traffic crashes result in both death and injury; hence the professionals need to be able to competently work with the injured and their families as well as the bereaved⁴⁷⁸. We recommend that these professionals should be appropriately-trained and experienced trauma and bereavement therapists as opposed to 'generic' counsellors⁴⁷⁹ – they require specialist knowledge in criminal justice and compensation processes as well as sensitivity in language⁴⁸⁰, an understanding of road trauma issues, and familiarity with, and willingness to work within, the guidelines published by the Australian Centre for Posttraumatic Mental Health⁴⁸¹. Furthermore, the therapists will require appropriate and regular continuing professional development opportunities funded by the service. These opportunities are necessary for best-practice but often not prioritised due to funding and logistical constraints⁴⁸².

Recommendation 9

The road trauma support service facilitates appropriately-trained volunteers to provide non-specialist supports

Professional therapists do not generally have first-hand experience of the effects that road trauma events have on families and on individuals. Road trauma victims, offenders, family members, friends and colleagues frequently express a need to normalise their feeling of overwhelming grief through speaking to others who have similar experiences and losses. Mutual-help support groups are especially useful for people experiencing socially-stigmatising phenomena⁴⁸³. Peer support follows a partnership model wherein power is shared and as such contrasts with bureaucratic and hierarchical organisations where help is professionalised⁴⁸⁴. The professionalisation of support renders personal experiences as 'baggage', thought to hinder or prevent the objectivity construed to be necessary in the provision of help, whereas personal experience is often valued highly by people who have experienced a trauma. Through the access to and contact with peers, the private experiences of loss, grief, and trauma are shared openly rather than silenced. Furthermore, volunteers provide a cost-effective method of providing non-professional support⁴⁸⁵. The volunteers would be selected and trained by the Volunteer Coordinator. To avoid exploitation, the volunteers would be reimbursed for any costs (e.g., petrol and parking) and would be acknowledged regularly (e.g., a quarterly 'thank you' morning tea and named in the annual report).

⁴⁷⁶ Kirchberg and Neimeyer (1991)

⁴⁷⁷ Kirchberg, Neimeyer, and James (1998)

⁴⁷⁸ Lord (2010)

⁴⁷⁹ Neimeyer (2009)

⁴⁸⁰ Lord (2010)

⁴⁸¹ Australian Centre for Posttraumatic Mental Health (2007)

⁴⁸² Breen (2011)

⁴⁸³ Davison, Pennebaker, and Dickerson (2000)

⁴⁸⁴ Schiff and Bargal (2000)

⁴⁸⁵ Payne (2002)

- **Point 7: The extent and delivery of associated advocacy, research and road safety education roles.**

Recommendation 10

The road trauma support service includes a suite of complementary direct and indirect services

The community counselling model⁴⁸⁶ provides the basis for the delivery of multiple direct and indirect support services to individual clients and the community. The application of this model to the proposed road trauma support service is outlined in Table 6. The model offers a unified approach to assist services to develop a multi-faceted and complementary combination of programmes and interventions that empower individuals to more readily access these services. Additionally, the model allows a 'voice' to people affected by road traffic crashes in that their needs and perspectives may be advocated.

Table 8

Applying the Community Counselling Model to Road Trauma

<i>Support</i>	<i>Community Services</i>	<i>Client Services</i>
Direct	Preventative education e.g., seminars and workshops about grief and trauma, (e.g., links with Office of Road Safety, Drug and Alcohol Office, Office of Youth Affairs); encouraging the development of coping skills; psycho-education	One-on-one interventions and outreach to vulnerable clients e.g., individualised therapeutic interventions for people in need and at-risk of need; bereavement and trauma services; specialist psychotherapy; therapeutic groups ⁴⁸⁷
Indirect	Influencing public policy ⁴⁸⁸ e.g., lobbying for legislative change, promotion of road safety messages to reduce future road trauma, partnerships with media, applied research	Client advocacy and consultation e.g., provision of grief and trauma education to enable the wider community to better support people directly affected by road trauma ⁴⁸⁹ ; supporting the development of mutual-help groups and provision of self-help materials and resources

- **Point 8: Resource requirements, including accommodation, administration, computing, communications and promotional materials.**

Recommendation 11

The road trauma support service be established as a non-profit organisation

The service should be established as an incorporated association under the *Associations Incorporation Act 1987* (WA) and be consistent with the characteristics necessary for receipt of Public Benevolent Institution and Deductible Gift Recipient status with the Australian Tax Office.

⁴⁸⁶ Lewis et al. (2003)

⁴⁸⁷ Murphy (2006)

⁴⁸⁸ Boss, Pikora, and Daube (2010)

⁴⁸⁹ Breen and O'Connor (2011)

Recommendation 12

The road trauma support service be governed by a Board of Management

Members would be selected based on having a keen interest in road trauma and its effects on the community, complementary professional skills and experiences (e.g., governance, financial management, legal matters), and represent the diversity of the WA community, in order to provide leadership, energy, and commitment to the establishment and sustainability of the service. An understanding of road trauma issues should be an essential criterion and experience of road trauma issues should be a desirable criterion for all positions. Membership of the Board would be on a volunteer (non-paid) basis and an appropriate size of the Board is up to 10 people. The service would supply/pay for meeting venues, appropriate catering and required resources, and any out-of-pocket costs incurred by Board members. Board members would need to comply with the *Associations Incorporation Act 1987* (WA) and require training in governance matters. Further, a Code of Conduct outlining expectations of the Board should be developed and followed.

Individuals (e.g., clients) and services may register with the organisation to receive relevant newsletters and other information but formal membership to the service will not be offered. Membership with voting rights does not guarantee the attraction and engagement of people with a range of road trauma experiences and demographics, nor does it preclude undue influence on or fragmentation of the Board of Management. Furthermore, none of the existing comprehensive road trauma support services in Australia (e.g., Road Trauma Support Services [Victoria], Road Trauma Support Tasmania, Road Trauma Support Team of South Australia) offers membership with voting rights.

Recommendation 13

The road trauma support service utilises a high-profile and appropriately-sensitive Patron

The identification and retention of a high-profile and appropriately sensitive patron of the service would be useful in raising the profile of the service and 'championing' its cause, including the dissemination of a wider road safety message, to the WA community. The patron would be chosen by the Board of Management in consultation with the Implementation Steering Committee.

Recommendation 14

The road trauma support service has a core salaried staff

In the first instance, salaried staff should include an Executive Officer (1FTE), Administration Officer (1FTE), Volunteer Coordinator (1FTE), and Services Coordinator (1FTE). The Administration Officer would provide the main contact point for the service and would maintain anonymous client information for evaluation and research purposes. The Volunteer Coordinator would recruit, train, and supervise the volunteers. The Services Coordinator would link clients to therapists as well as develop and maintain links and partnerships with relevant services to ensure that clients are supported appropriately (see Recommendation 20). An IT consultant will be required in the initial stages in setting-up the premises and constructing the website and would then be contracted as required.

Recommendation 15

The road trauma support service be situated in community-based premises accessible by public transport

The road trauma support service requires community-based premises in the metropolitan area of Perth. Community-based premises are likely to be less threatening than hospital or government premises. Additionally, proximity to public transport options is required due to the likelihood that some clientele might have physical impairments and/or experience difficulty driving or occupying a motor vehicle due to road trauma issues.

Recommendation 16

The road trauma support service be complemented by information packages, a brochure, and a website

People bereaved through road traffic crashes in WA report they would like information provided to them in topics such as coping strategies, what to expect from a sudden and violent bereavement, and where to access support, and that this information would be most beneficial in a booklet form and received soon after their loved one's death⁴⁹⁰. An information package, developed and disseminated under the auspices of the road trauma support service, is crucial because current services risk losing contact with the families soon after death notification and identification processes. We recommend the information and support pack be modelled on the *Information and Support Pack for those Bereaved by Suicide and Other Sudden Death* produced by the Ministerial Council of Suicide Prevention and disseminated through the Office of the Coroner⁴⁹¹. Similar packs could be design for other user groups. The receipt of an information package in the post would be useful without intruding on those who do not require support.

The service's website should be simple, easy to navigate, and based on universal design principles⁴⁹². It should include information about road trauma and its effects, contact details for the service, a summary of the different types of support provided by the service (professional therapeutic interventions for trauma and bereavement as well as peer supports), and links to other services, especially crisis services such as Lifeline, Samaritans, and the Kids Helpline.

- **Point 9: Estimated costs associated with establishing and sustaining recommended road trauma support services in WA, and recommended funding providers;**

Recommendation 17

The road trauma support service has an initial annual budget and recurrent funding

Developing a budget for establishing the road trauma support service requires both fixed and variable costs. Fixed costs are those that do not vary with the level of service provided. Examples include premises (e.g., rent, refurbishment, electricity, internet and telephone connections), office equipment (e.g., computers, chairs, tables, stationary, etc.), and staff recruitment and training. Variable costs are costs that do vary with the level of service provided. Examples include printing and distribution of brochures (which may of course become a fixed cost in subsequent years when there is clearer indication of service demand),

⁴⁹⁰ Breen (2007)

⁴⁹¹ <http://www2.mcsp.org.au/community/resources/bereavement/support.html>

⁴⁹² Horton (2005)

salary of core staff and trauma and bereavement therapists' fees, and overhead expenses (which become fixed costs in subsequent years). It is expected that the budget in the first year will be much higher than for subsequent years due to establishment costs. In subsequent years, however, costs that will vary with level of service provided include salary of staff and therapists' fees, but it is expected that these salaries and fees will consume a large proportion of the variable costs.

A thorough analysis of the budget required for this project should be completed once the recommendations are accepted. The Victorian model indicated that ideally it would operate with a budget of \$1 to \$1.5 million per year. While WA may use this figure as a benchmark, at this stage it is premature to commit to any specific amount. The reliance on annual budgets stifles forward planning^{493,494,495}; as such, the proposed service should be funded initially on an annual basis with the option of moving to three-year contracts if monitoring requirements are met (Recommendation 18).

- **Point 10: Stakeholder details and contacts, including government, non-government organisations, industry and community groups.**

The stakeholders include the members of the reference group (see page 3), the organisations they represent (where applicable), and the interstate road trauma support services.

- **Point 11: An evaluation and reporting framework to monitor, assess and provide constructive feedback on the effectiveness of the WA road trauma support service, on an ongoing basis.**

Recommendation 18

The road trauma support service has an evaluation and reporting framework

An evaluation and reporting framework is required to monitor, assess, and provide constructive feedback on the effectiveness of the WA road trauma support service, on an ongoing basis, to ensure that the service is cost-effective, efficacious, and ethical⁴⁹⁶. We recommend the service is funded initially for a period of three years, conditional on satisfactory completion of each interim report, so that the service can 'find its feet' and engage in future planning. We recommend quarterly and six-monthly financial statements be provided to the funding body in the first two years of the service. Following this two-year period, annual reports should be provided, outlining the service's history and current staff, promotion of services, referral pathways to and from the service, services delivered and to whom and where, income and expenses. All financial reports must be audited independently and there must be accountability for all staff and the Board of Management. The direct services in particular require valid indicators of efficacy and must include client and therapist satisfaction surveys but ideally will also include objective data of intervention efficacy (as

⁴⁹³ Face-to-face interview with Paul Ashton, Chief Executive Officer of RTSSV, 12th July 2011

⁴⁹⁴ Face-to-face interview with Sharon Neville, Secretary and Treasurer, RTSTSA, 8th August 2011

⁴⁹⁵ Face-to-face interview with Graeme Lunson, Executive Officer of RTST, 13th July 2011

⁴⁹⁶ Schut and Stroebe (2011)

satisfaction with services is not the same as service efficacy) and provides the potential for applied research with anonymous data⁴⁹⁷.

- **Point 12: An outline of essential steps to ensure the successful introduction of sustainable road trauma support services across WA.**

Recommendation 19

The road trauma support be established in incremental steps commencing as soon as possible to be in operation by the end of 2012

The road trauma support service should be established by following these steps, and in association with an Implementation Steering Group to provide advice on the establishment arrangements. The steps should be achieved within 12 months of commencement. The service could be operating by the end of 2012 and may be launched as part of World Day of Remembrance for Road Traffic Victims (November 2012)⁴⁹⁸:

1. Obtain funding approval and backing;
2. Decide on the service's name and annual budget;
3. Recruit the Board of Management;
4. Find and occupy premises, taking into account the location and proximity to public transport;
5. Hire the Executive Officer and determine the Patron;
6. Hire other staff; develop links with specialist psychotherapeutic intervention providers; establish website and toll-free state-wide telephone line;
7. Develop, print, and begin dissemination of service brochure to general practitioners (through the Divisions of General Practice) so they know to refer patients to the service for Medicare-funded supports, and to staff in hospitals, Victim Support Service, Office of the Coroner, WA Police, insurance companies, Lifeline, Health Direct, and ConnectGroups for additional referrals. The contact details should also be added to relevant online communities such as the Journey Beyond Road Trauma website (see also Recommendation 20);
8. Foster and develop links with government departments and community groups for the delivery of community education programmes; and
9. Develop a three-year strategic plan.

Recommendation 20

The road trauma support service be linked and work in partnership with other services and supports

Notwithstanding the existing limitations and gaps identified in Section 4, existing services provide some valuable services to people affected by road traffic crashes. In drawing on a public health approach, the proposed road trauma support service requires partnerships with, and referral pathways from and to, these existing services, including WA Police, Office of the Coroner and its Coronial Counselling Service, Victim Support Service, general practitioners, community-based services (e.g., Lifeline, Carers WA, Volunteers WA, Sussex Street Community Law) mutual help groups (e.g., The Compassionate Friends) and their peak body (ConnectGroups), community groups (e.g., Rotary, Lions, and Apex clubs), online communities (e.g., Journey Beyond Road Trauma), road user groups (e.g., caravanning and

⁴⁹⁷ Schut and Stroebe (2011)

⁴⁹⁸ <http://www.worlddayofremembrance.org/>

four-wheel drive clubs) funeral companies, hospitals, Insurance Commission of WA, general practitioners, who play a vital role in the care of bereaved people⁴⁹⁹, and road trauma support services for Aboriginal Australians⁵⁰⁰. In order for these services and resources to form referral pathways, the partnership needs to take the form where these services are aware of the road trauma support service and the road trauma support services is able to demonstrate its credibility and appropriateness to receive referrals. This information can be disseminated to the community via media links, including the RAC magazine.

Additional recommendations

Recommendation 21

The road trauma support service meet the access needs of underserved groups including culturally and linguistically diverse people, Indigenous Australians, and people with disabilities

The road trauma support service must be able to meet the needs of culturally and linguistically diverse groups and people with disabilities. The service must engage (and pay for) interpreters (e.g., WA Interpreters⁵⁰¹) for and incorporate road trauma support services for Aboriginal and Torres Strait Islander Australians⁵⁰². The service must occupy community-based premises with disability access (see Recommendation 15) and its website must following the principles of universal design (see Recommendation 16).

Recommendation 22

The road trauma support service be complemented by best-practice death notification and the re-establishment of a Family Liaison Officer in WA Police's Major Crash section

Notification of a sudden death is often described as the most traumatic life experience⁵⁰³ and as such, requires best-practice death notification strategies; research demonstrates these strategies are beneficial for the bereaved in reducing trauma as well as for the professionals delivering the notification⁵⁰⁴. We do not recommend the road trauma support service brochure be disseminated at this time.

Rather than training the investigators to be more sensitive and empathetic, which may not fit their role because of their need to remain 'objective' and detached, a dedicated liaison officer (or officers) could provide support to the bereaved (some face-to-face in the metropolitan area by primarily via telephone throughout the state) without impeding the investigation process. WA Police previously employed a part-time Family Liaison Officer within the Major Crash section but the duties of this role have now been absorbed into Investigating Officer positions. Similar positions continue to exist elsewhere, for example, South Australia, where the Major Crash Investigation Unit has included a Victim Contact Officer since 2000. This Officer delivers support, provides information about support services, and advocates for victims' rights⁵⁰⁵ and would assist in referral to the service proposed herein.

⁴⁹⁹ McGrath (2010)

⁵⁰⁰ Ferguson and Kehoe Watson (2011)

⁵⁰¹ www.wainterpreters.com.au

⁵⁰² Ferguson and Kehoe Watson (2011)

⁵⁰³ Lord (2010)

⁵⁰⁴ Lord and Stewart (2008)

⁵⁰⁵ Crameri (n.d.)

Strengths and Limitations of the Project

This report provides an original, contextual, and data-driven account of (a) the consequences of road crashes, (b) current services in WA, (c) trauma and bereavement service delivery, and (d) existing road trauma support services available in other Australian states. Attempts were made to ensure the process was as rigorous as possible, including the using multiple sources of data and conducting the research in a team. The project's key strength is the involvement of the stakeholder reference group – its members including representatives from relevant services as well as people affected personally by road trauma; this diversity and depth enhances the study's ability to contribute to practice⁵⁰⁶. Further, the report provides the basis for the development and evaluation of the future road trauma support service in WA.

⁵⁰⁶ Daley et al. (2007)

9.0 REFERENCES

- Access Economics. (2010). *The economic value of informal care in 2010*. Canberra, Australia: Author. Accessed 27th September 2011 from <http://national.carersaustralia.com.au/?/national/news/view/1982>
- American Psychiatric Association (2000). *Diagnostic and statistical manual of mental disorders (DSM-IV-TR)*. Washington, DC: Author.
- Aoun, S. M., Breen, L. J., O'Connor, M., Rumbold, B., & Nordstrom, C. (in press). A public health approach to bereavement support services in palliative care: The way forward through partnerships. *Australian and New Zealand Journal of Public Health*.
- Australian Bureau of Statistics. (2008). *A profile of carers in Australia* (Cat. No. 4448.0). Canberra: Australia: Author. Accessed 26th September 2011 from <http://www.abs.gov.au/AUSSTATS/abs@.nsf/Lookup/4448.0Main+Features12008>
- Australian Bureau of Statistics. (2009). *Household income and income distribution, Australia, 2007-08* (Cat. No. 6523.0). Canberra: Australia: Author. Accessed 23rd August 2011 from <http://www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/6523.0200708?OpenDocument>
- Australian Bureau of Statistics. (2011a). *Causes of death Australia 2009* (Cat. No. 3303.0). Canberra, Australia: Author. Accessed 30th May 2011 from <http://www.abs.gov.au/AUSSTATS/abs@.nsf/Lookup/3303.0Main+Features12009?OpenDocument>
- Australian Bureau of Statistics. (2011b). *Disability, ageing and carers, Australia: State tables for Western Australia* (Table 32). Canberra, Australia: Author. Accessed 27th September 2011 from <http://www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/4430.02009?OpenDocument>
- Australian Centre for Posttraumatic Mental Health. (2007). *Australian guidelines for the treatment of adults with acute stress disorder and posttraumatic stress disorder: ASD and PTSD treatment guidelines*. Melbourne, Victoria: Author. Accessed 5th July 2011 from <http://www.acpmh.unimelb.edu.au/resources/resources-guidelines.html#1>
- Australian Institute of Health and Welfare. (2011). *Trends in serious injury due to land transport accidents, Australia* (Injury research and statistics series no. 56. Cat. no. INJCAT 132). Canberra, Australia: Author. Accessed 23rd September 2011 from <http://www.aihw.gov.au/publication-detail/?id=10737418595>
- Australian Transport Council. (2011). *National Road Safety Strategy 2011-2020*. Accessed 26th September 2011 from <http://www.atcouncil.gov.au/documents/atcnrss.aspx>
- Barak, A., Hen, L., Boniel-Nissim, M., & Shapira, N. (2008). A comprehensive review and meta-analysis of the effectiveness of Internet-based psychotherapeutic interventions. *Journal of Technology in Human Services*, 26, 109-160.
- Barak, A., Klein, B., & Proudfoot, J. G. (2009). Defining Internet-supported therapeutic interventions. *Annual Behavioural Medicine*, 38, 4-17.
- Bateman, V. (2010). Death as a result of culpable driving: Impact and intervention. *Grief Matters: The Australian Journal of Grief and Bereavement*, 13(1), 16-20.
- Benkel, I., Wijk, H., & Molander, U. (2005). Family and friends provide most social support for the bereaved. *Palliative Medicine*, 23, 141-149.
- Big win for road safety. (2011, June-July). *Horizons*, p. 10.

- Blanchard, E. B., & Hickling, E. J. (2004). *After the crash: Psychological assessment and treatment of survivors of motor vehicle accidents* (2nd ed.). Washington, DC: American Psychological Association.
- Blaszczynski, A., Panasetis, P. & Silove, D. (1998). *The road ahead: A self-help guide for road trauma sufferers and their carers*. Sydney, Australia: University of New South Wales Press.
- Boelen, P. A., de Keijser, J., van den Hout, M. A., & van den Bout, J. (2007). Treatment of complicated grief: A comparison between cognitive-behavioural therapy and supportive counselling. *Journal of Consulting and Clinical Psychology*, 75, 277-284.
- Bonanno, G. A., Boerner, K., & Wortman, C. B. (2008). Trajectories of grieving. In M. S. Stroebe, R. O. Hansson, H. Schut, & W. Stroebe (Eds.), *Handbook of bereavement research and practice: Advances in theory and intervention* (pp. 287-307). Washington, DC: American Psychological Association.
- Boss, A., Pikora, T., & Daube, M. (2010, September). *Road safety and public health advocacy: The way forward*. Paper presented at the Insurance Commission of Western Australia Road Safety Forum, Perth, Western Australia.
- Brain Injury Australia. (2011). *Towards a national carer strategy: A discussion paper from the Australian Government*. Comments from Brain Injury Australia. Accessed 27th September 2011 from [http://www.bia.net.au/docs/Nat%20Carers%20Strategy_BIA%20member%20submissi on_Jan11.pdf](http://www.bia.net.au/docs/Nat%20Carers%20Strategy_BIA%20member%20submission_Jan11.pdf)
- Breen, L. J. (2007). *Silenced voices: Experiences of grief following road traffic crashes in Western Australia*. Unpublished doctoral thesis, Edith Cowan University, Perth, Western Australia.
- Breen, L. J. (2009). Early childhood service delivery for families living with childhood disability: Disabling families through problematic implicit ideology. *Australasian Journal of Early Childhood*, 34(4), 14-21.
- Breen, L. J. (2011). Professionals' experiences of grief counselling: Implications for bridging the gap between research and practice. *Omega: The Journal of Death and Dying*, 62, 285-303.
- Breen, L. J., & O'Connor, M. (2007). The fundamental paradox in the grief literature: A critical reflection. *Omega: The Journal of Death and Dying*, 55, 199-218.
- Breen, L. J., & O'Connor, M. (2010). Acts of resistance: Breaking the silence of grief following crash fatalities. *Death Studies*, 34, 30-53.
- Breen, L. J., & O'Connor, M. (2011). Family and social networks after bereavement: Experiences of support, change, and isolation. *Journal of Family Therapy*, 33, 98-120.
- Browning, R. (2002). Where are the protests? *British Medical Journal*, 324, 1165.
- Bureau of Infrastructure, Transport and Regional Economics. (2009). *Cost of road crashes in Australia 2006* (Report 118). Canberra: Author. Accessed 30th May 2011 from <http://www.bitre.gov.au/info.aspx?ResourceId=748&NodeId=25>
- Bureau of Transport Economics. (2000). *Road crash costs in Australia (report 102)*. Canberra, Australian Capital Territory, Australia: Author.
- Butler, A. C., Chapman, J. E., Forman, E. M., & Beck, A. T. (2006). The empirical status of cognitive-behavioral therapy: A review of meta-analyses. *Clinical Psychology Review*, 26, 17-31.
- Chan, J. (2007). Carers' perspective on respite for persons with acquired brain injury. *International Journal Rehabilitation Research*, 30, 137-146.

- Charlton, R., Rumsey, N., Partridge, J., Barlow, J., & Saul, K. (2003). Disfigurement – neglected in primary care? *British Journal of General Practice*, 53, 6-8.
- Clark, J. (2004). Deceased drivers: Memorialisation and road safety. *Roadwise*, 15(1), 11-13.
- Clark, S. J., Hillman, S. D., & Western Australian Youth Suicide Advisory Committee. (2001). *Information and support pack for those bereaved by suicide or other sudden death*. Perth, Western Australia, Australia: Western Australian Youth Suicide Advisory Committee.
- Cowan, S. (2005a, November 16). Major crash officer wants trauma compo. *The West Australian*, p. 13.
- Cowan, S. (2005b, November 19). Stressed out cops may have to leave force. *The West Australian*, p. 48.
- Cramer, R. (n.d.). *The role of Victim Contact Officer South Australian Police*. Accessed 5th July 2011 from <http://www.aic.gov.au/events/aic%20upcoming%20events/2002/~media/conferences/policewomen3/cramer.ashx>
- Cummins, R. A., Hughes, J., Tomy, A., Gibson, A., Woerner, J., & Lai, L. (2007). *The wellbeing of Australians – Carer health and wellbeing*. Melbourne, Australia: Australian Centre on Quality of Life, Deakin University. Accessed 27th September 2011 from <http://www.deakin.edu.au/research/acqol/auwbi/survey-reports/survey-017-1-report.pdf>
- Currier, J. M., Holland, J. M., & Neimeyer, R. A. (2007). The effectiveness of bereavement intervention with children: A meta-analytic review of controlled outcome research. *Journal of Clinical Child and Adolescent Psychology*, 36, 253-259.
- Currier, J.M., Neimeyer, R.A., & Berman, J. S. (2008). The effectiveness of psychotherapeutic interventions for bereaved persons: A comprehensive quantitative review. *Psychological Bulletin*, 134, 648-661.
- Curtis, K., & Newman, T. (2001). Do community-based support services benefit bereaved children? A review of empirical evidence. *Child: Care, Health and Development*, 27, 487-495.
- Daly, J., Willis, K., Small, R., Green, J., Welch, N., Kealy, M., & Hughes, E. (2007). A hierarchy of evidence for assessing qualitative health research. *Journal of Clinical Epidemiology*, 60, 43-49.
- Davison, K. P., Pennebaker, J. W., & Dickerson, S. S. (2000). Who talks? The social psychology of illness support groups. *American Psychologist*, 55, 205-217.
- Downes, J. (2010). Trauma matters too. *Grief Matters: The Australian Journal of Grief and Bereavement*, 13(1), 12-15.
- Dunn, L. T., Patterson, M., & Boot, D. A. (2000). Head injury in the severely injured: Long-term follow-up in 157 patients. *British Journal of Neurosurgery*, 14, 219-224.
- Edwards, B., Gray, M., Baxter, J., & Hunter, B. (2007). *The tyranny of distance? Carers in remote and regional areas of Australia*. Canberra, Australia: Carers Australia and Australian Institute of Family Studies. Accessed 27th September 2011 from <http://www.aifs.gov.au/institute/pubs/pubstitlet.php>
- Evans, J. (2010). Road Trauma Support Services Victoria counselling services: Final report of review procedures. Jennifer Evans Consulting.
- Federation of European Road Traffic Victims. (1993). *Study of the physical, psychological, and material secondary damage inflicted on the victims and their families by road crashes*. Geneva: Author.

- Federation of European Road Traffic Victims. (1995). *Impact of road death and injury: research into the principal causes of the decline in quality of life and living standard suffered by road crash victims and victim families: Proposal for improvements*. Geneva: Author.
- Ferguson, C., & Kehoe Watson, J. (2011). *An evaluation of injury prevention strategies and road trauma support services for Aboriginal Australians in Western Australia – Interim report to the Health Department of Western Australia*. Perth, Western Australia: ConnectGroups – Support Groups Association of Western Australia.
- Forbes, D., Creamer, M. C., Phelps, A. J., Couineau, A.-L., Cooper, J., A., Bryant, R. A., McFarlane, A. C., ... & Raphael, B. (2007). Treating adults with acute stress disorder and post-traumatic stress disorder in general practice: A clinical update. *Medical Journal of Australia*, 187, 120-123.
- Giles, M. (2001). Data for the study of road crashes in Australia. *Australian Economic Review*, 34, 222-230.
- Giles, M. (2003a). The cost of road crashes: A comparison of method and recent Australian estimates. *Journal of Transport Economics and Policy*, 37, 95-110.
- Giles, M. (2003b). Correcting for selectivity bias in the estimation of road crash costs. *Applied Economics*, 35, 1291-1301.
- Grad, O. T., & Zavasnik, A. (1999). Phenomenology of bereavement process after suicide, traffic accident and terminal illness (in spouses). *Archives of Suicide Research*, 5, 157-172.
- Hansson, R. O., & Stroebe, M. S. (2003). Grief, older adulthood. In M. Bloom & T. P. Gullotta (Eds.), *Encyclopedia of primary prevention and health promotion* (pp. 515-521). New York: Kluwer Academic.
- Hawley, C. A., Ward, A. B., Magnay, A. R., & Long, J. (2003). Parental stress and burden following traumatic brain injury amongst children and adolescents. *Brain Injury*, 17, 1-23.
- Haywood, M. (1998). Road trauma: Dealing with loss and grief. *Journal of Family Studies*, 4, 228-229.
- Hetherington, A., Munro, A., & Mitchell, M. (1997). At the scene: Road accidents and the police. In M. Mitchell (Ed.), *The aftermath of road accidents: Psychological social and legal consequences of an everyday trauma* (pp. 113-122). London: Routledge.
- Hillman, S., Green, A., & Silburn, S. (1999). *A study of families bereaved by suicide*. Perth, Western Australia: TVW Institute of Child Health Research and the Youth Suicide Advisory Committee.
- Horton, S. (2005). *Access by design: A guide to universal usability for web designers*. Berkeley, CA: New Riders Press.
- Hughes, J. (2007). Caring for carers: The financial strain of caring. *Family Matters*, 76, 32-33.
- Janoff-Bulman, R. (1992). *Shattered assumptions: Towards a new psychology of trauma*. New York: Free Press.
- Jeavons, S. (1997). Voluntary organisations and their role in providing support in the aftermath of accidents. In M. Mitchell (Ed.), *The aftermath of road accidents: Psychological social and legal consequences of an everyday trauma* (pp. 3205-216). London: Routledge.
- Job, R. F. S. (1999). The road user: The psychology of road safety. In J. Clark (Ed.), *Safe and mobile: Introductory studies in traffic safety* (pp. 21-55). Armidale New South Wales, Australia. Emu Press.

- Jordan, J. R., & Neimeyer, R. A. (2003). Does grief counseling work? *Death Studies*, 27, 765-786.
- Keir, J. (2000). The Road Trauma Support Team Victoria: How we can help you. *In-Psych*, 22(4), 25.
- King, R., Bambling, M., Reid, W., & Thomas, I. (2006). Telephone and online counselling for young people: A naturalistic comparison of session outcome, session impact, and therapeutic alliance. *Counselling and Psychotherapy Research*, 6, 175-181.
- Kirchberg, T. M., & Neimeyer, R. A. (1991). Reactions of beginning counselors to situations involving death and dying. *Death Studies*, 15, 603-610.
- Kirchberg, T. M., Neimeyer, R. A., & James, R. K. (1998). Beginning counselors' death concerns and empathic responses to client situations involving death and grief. *Death Studies*, 22, 99-120.
- Kiropoulos, L., Klein, B., Austin, D. W., Gilson, K., Pier, C., Mitchell, J., & Ciechomski, L. (2008). Is internet-based CBT for panic disorder and agoraphobia as effective as face-to-face? *Journal of Anxiety Disorders*, 22, 1273-1284.
- Klass, D., Silverman, P. R., & Nickman, S. L. (Eds.). (1996). *Continuing bonds: New understandings of grief*. Philadelphia, PA: Taylor & Francis.
- Knight, R. G., Devereux, R., Godfrey, H. P. D. (1998). Caring for a family member with a traumatic brain injury. *Brain Injury*, 12, 467-481.
- Kobayaski, I., Sledjeski, E. M., Spoonster, E., Fallon, W. F., & Delahanty, D. L. (2008). Effects of early nightmares on the development of sleep disturbances in motor vehicle accident victims. *Journal of Traumatic Stress*, 21, 548-555.
- Lawley, J. (2006). Reflections on the founding of TCF from Joe Lawley co-founder. *The Compassionate Friends Australian National Newsletter*, 12(2), 9-10.
- Lehman, D. R., Lang, E. L., Wortman, C. B., & Sorenson, S. B. (1989). Long-term effects of sudden bereavement: Marital and parent-child relationships and children's reaction. *Journal of Family Psychology*, 2, 344-367.
- Lehman, D. R., Wortman, C. B., & Williams, A. F. (1987). Long-term effects of losing a spouse or child in a motor vehicle crash. *Journal of Personality and Social Psychology*, 52, 218-231.
- Lewis, J. A., Lewis, M. D., Daniels, J. A., & D'Andrea, M. J. (2003). *Community counseling: Empowerment strategies for a diverse society* (3rd ed.). Pacific Grove, CA: Thomson.
- Lloyd-Bostock, S. (1997). The natural history of claims for compensation after an accident. In M. Mitchell (Ed.), *The aftermath of road accidents: Psychological, social, and legal consequences of an everyday trauma* (pp. 135-144). London: Routledge.
- Lobb, E. A., Kristjanson, L. J., Aoun, S. M., Monterosso, L., Halkett, G. K. B., & Davies, A. (2010). Predictors of complicated grief. A systematic review of empirical studies. *Death Studies*, 34, 673-698.
- Lord, J. H. (2000). *No time for goodbyes: Coping with sorrow, anger and injustice after a tragic death* (5th ed.). Oxnard, CA: Pathfinder.
- Lord, J. H. (2010). Real MADD: How to help road trauma survivors. *Grief Matters: The Australian Journal of Grief and Bereavement*, 13(1), 4-11.
- Lord, J. H., & Stewart A. E. (2008). *I'll never forget those words: A practical guide to death notification*. Burnsville, NC: Compassion Press.
- Lucke, K. T., Coccia, H., Goode, J. S., & Lucke, J. F. (2004). Quality of life in spinal cord injured individuals and their caregivers during the initial 6 months following rehabilitation. *Quality of Life Research*, 13, 97-110.

- Marchant, R. J., Hill, D. L., Caccianiga, R. A., & Gant, P. D. (2008). *Reported road crashes in Western Australia 2006*. Perth, Australia: Road Safety Council of Western Australia. Accessed 30th May 2011 from <http://www.ors.wa.gov.au/ResearchFactsStats/Pages/AnnualCrashStats.aspx>
- Martin, T. L. & Doka, K. J. (2000). *Men don't cry... women do: Transcending gender stereotypes of grief*. Philadelphia: Brunner/Mazel.
- Mayou, R. (1997). The psychiatry of road traffic accidents. In M. Mitchell (Ed.), *The aftermath of road accidents: Psychological social and legal consequences of an everyday trauma* (pp. 33-48). London: Routledge.
- Mayou, R., Bryant, B., & Duthie, R. (1993). Psychiatric consequences of road traffic accidents. *British Medical Journal*, 307, 647-651.
- Mayou, R., Bryant, B., Duthie, R., & Talbot, J. R. (1995). Psychiatric consequences of road traffic accidents. *British Medical Journal*, 307, 647-651.
- Mayou, R. A., Ehlers, A., & Hobbs, M. (2000). Psychological debriefing for road traffic accident victims: Three-year follow-up of a randomised controlled trial. *The British Journal of Psychiatry*, 176, 589-593.
- McGrath, P. (2010). Surviving spousal bereavement: Insights for GPs. *Australian Family Physician*, 39, 780-783.
- Mercer, D. (1995). *Mediating effects of religious participation and personal religiosity on recovery from victimization by a drinking driver. Report from drunken victim impact panels: Victim outcomes, preliminary report* (Grant No. 1-R01-M#48987). Washington, DC: Department of Health and Human Resources, National Institute of Mental Health.
- Mitchell, M. (1997). Death and injury on the road. In M. Mitchell (Ed.), *The aftermath of road accidents: Psychological social and legal consequences of an everyday trauma* (pp. 3-14). London: Routledge.
- Mitchley, N., Gray, J. M., & Pentland, B. (1996). Burden and coping among the relatives and carers of brain-injured survivors. *Clinical Rehabilitation*, 10, 3-8.
- Murphy, S. A. (2006). Evidenced-based interventions for parents following their children's violent deaths. In E. K. Rynearson (Ed.), *Violent death: Resilience and intervention beyond the crisis* (pp. 175-194). New York: Routledge.
- Murphy, S. A., Johnson, L. C., Chung, I.-J., & Beaton, R. D. (2003). The prevalence of PTSD following the violent death of a child and predictors of change 5 years later. *Journal of Traumatic Stress*, 16, 17-25.
- Murphy, S. A., Johnson, L. C., Wu, L., Fan, J. J., & Lohan, J. (2003). Bereaved parents' outcomes 4 to 60 months after their children's death by accident suicide, or homicide. A comparative study demonstrating differences. *Death Studies*, 27, 39-61.
- National Institute for Health and Clinical Excellence. (2004). *Guidance on cancer services: Improving supportive and palliative care for adults with cancer. The Manual*. London: Author. Accessed 25th January 2011 from <http://guidance.nice.org.uk/CSGSP/Guidance/pdf/English>
- Neimeyer, R. A. (Ed.). (2001). *Meaning reconstruction and the experience of loss*. Washington, DC: American Psychological Association.
- Neimeyer, R. A. (2009). *Grief and bereavement counseling*. Accessed 21st June 2011 from <http://web.me.com/neimeyer/Home/Scholarship.html>
- Norris, F. H. (1992). Epidemiology of trauma: Frequency and impact of different potentially traumatic events on different demographic groups. *Journal of Consulting and Clinical Psychology*, 60, 409-418.

- Office of Road Safety. (2009) *Towards Zero Road Safety Strategy: To Reduce Road Trauma in Western Australia 2008-2020*. Accessed 26th September 2011 from <http://ors.wa.gov.au/Towards-Zero.aspx>
- Oxley, J. A., & Fildes, B. N. (1993). *Pilot study of the long-term effects of road crashes*. Clayton, Victoria: Monash University Accident Research Centre. Accessed 26th September 2011 from http://www.monash.edu.au/muarc/reports/rpts_cr.html
- Parker, C., Parsons, J., & Pettet, T.-A. (2002, November). *Road Trauma Counselling Service*. Paper presented at the Road Safety Research, Policing and Education Conference, Adelaide, Australia. Accessed 23rd May 2011 from <http://www.rsconference.com/index.html>
- Payne, S. (2002). Dilemmas in the use of volunteers to provide hospice and bereavement support: Evidence from New Zealand. *Mortality*, 7, 139-154.
- Perlesz, A., Kinsella, G., Crowe, S. (2000). Psychological distress and family satisfaction following traumatic brain injury: Injured individuals and their primary, secondary, and tertiary carers. *Journal of Head Trauma Rehabilitation*, 15, 909-929.
- Piper, W. E., Ogrodniczuk, J. S., Joyce, A. S., Weideman, R., & Rosie, J. S. (2007). Group composition and group therapy for complicated grief. *Journal of Consulting and Clinical Psychology*, 75, 116-125.
- Pirkis, J., Harris, M., Hall, W., & Ftanou, M. (2011). *Evaluation of the Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule Initiative: Summative evaluation*. Melbourne, Australia: Centre for Health Policy, Programs and Economics.
- Ponsford, J., & Schönberger, M. (2010). Family functioning and emotional state two and five years after traumatic brain injury. *Journal of the International Neuropsychological Society*, 16, 305-317.
- Prigerson, H. G., Jacobs, S., C., Parkes, C. M., Aslan, M., Goodkin, K., Raphael, B., Marwit, S. J., ... & Maciejewski, P. K. (2009). Prolonged Grief Disorder: Psychometric Validation of Criteria Proposed for *DSM-V* and *ICD-11*. *PLOS Medicine*, 6(8). Available from <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2711304/pdf/pmed.1000121.pdf>
- Prigerson, H. G., Silverman, G. K., Jacobs, S.C., Maciejewski, P. K., Kasl, S. V., & Rosenheck, R. A. (2001). Traumatic grief, disability, and the underutilization of health services: A preliminary examination. *Primary Psychiatry*, 8, 61-66.
- Prigerson, H. G., Vanderwerker, L. C., & Maciejewski, P. K. (2008). A case for inclusion of prolonged grief disorder in DSM-IV. In M. S. Stroebe, R. O. Hansson, H. Schut, & W. Stroebe, (Eds.), *Handbook of bereavement research and practice: Advances in theory and intervention* (pp. 165-186). Washington, DC: American Psychological Association.
- Road Safety Council Act 2002 (as at 17th August 2011). Accessed 28th September 2011 from www.slp.wa.gov.au
- Road Trauma Support Services. (n.d.). *Annual report 2009 – 2010*. Blackburn North, Victoria: Author. Accessed 4th April 2011 from <http://www.rtssv.org.au/publications>
- Roberts, N., Kitchiner, N., Kenardy, J., & Bisson, J. (2009). Systematic review and meta-analysis of multiple-session early interventions following traumatic events. *American Journal of Psychiatry*, 166, 293-301.
- Rusch, M. D. (1998). Psychological response to trauma. *Plastic Surgery Nursing*, 18, 147-153.
- Schiff, M., & Bargal, D. (2000). Helping characteristics of self-help and support groups: Their contributions to participants' subjective well-being. *Small Group Research*, 31, 275-304.

- Shear, K., Frank, E., Houck, P. R., & Reynolds, C. F. (2005). Treatment of complicated grief: A randomized controlled trial. *Journal of the American Medical Association*, 293, 2601-2608.
- Schut, H., & Stroebe, M. (2011). Challenges in evaluating adult bereavement services. *Cruse Bereavement Care*, 30(1), 5-9.
- Schut, H., Stroebe, M. S., van den Bout, J., & Terheggen, M. (2001). The efficacy of bereavement interventions: Determining who benefits. In M. S. Stroebe, R. O. Hansson, W. Stroebe, & H. Schut (Eds.), *Handbook of bereavement research: Consequences, coping, and care* (pp. 705-727). Washington, DC: American Psychological Association.
- Shandley, K., Klein, B., Kyrios, M., Austin, D., Ciechomski, L., & Murray, G. (2011). Training postgraduate psychology students to deliver psychological services online. *Australian Psychologist*, 46, 120-125.
- Shanfield, S. B., & Swain, B. J. (1984). Death of adult children in traffic accidents. *Journal of Nervous and Mental Disease* 172, 533-553.
- Spooren, D. J., Henderick, H., & Jannes, C. (2000-2001). Survey description of stress of parents bereaved from a child killed in a traffic accident: A retrospective study of a victim support group. *Omega: The Journal of Death and Dying*, 42, 171-185.
- Sprang, G. (1997). PTSD in surviving family members of drunk driving episodes: Victim and crime related factors. *Families in Society*, 78, 632-641.
- Stroebe, M., & Schut, H. (1999). The dual process model of grief: Rationale and description. *Death Studies*, 23, 197-224.
- Tehrani, N. (2004). Road victim trauma: An investigation of the impact on the injured and bereaved. *Counselling Psychology Quarterly*, 17, 361-373.
- The Compassionate Friends. (2003, June). *Reflections*, 22(2).
- The Compassionate Friends, (n.d.). Information pamphlet [Brochure].
- Vanderwerker, L. C., Laff, R. E., Kadan-Lottick, N. S., McColl, S., Prigerson, H. G. (2005). Psychiatric disorders and mental health service use among caregivers of advanced cancer patients. *Journal of Clinical Oncology*, 23, 6820-6821.
- Victim Support Service. (n.d.). *What do I do now? Assistance for families dealing with the unlawful death of a family member*. Perth, Western Australia: Author. Accessed 18th July 2011 from <http://www.courts.dotag.wa.gov.au/files/WhatNow.pdf>
- Western Australian Police Service. (n.d.). *When someone dies in a road fatality in Western Australia: Things you need to know*. Perth, Australia: Author.
- Williams, M. (1997). The other victims. *Nursing Standard*, 11(46), 18.
- Willis, K., Cameron, P., & Igoe, P. (1997). Building community networks: A road trauma education and training program for rural areas. *Australian Journal of Rural Health*, 5, 6-10.
- World Health Organization. (2004). *World report on road traffic injury prevention*. Geneva: Author.

10.0 APPENDICES

Appendix A: Project Personnel

Dr Breen is a Lecturer in the School of Psychology and Speech Pathology, Curtin Health Innovation Research Institute, Curtin University. Her PhD explored the psychosocial experience for people bereaved through the death of a family member in a road traffic crash in WA. The thesis won the 2007 Australian Psychological Society's Psychology of Relationships Interest Group Thesis Award and has been published as a book as well as several book chapters and academic journal articles in *Death Studies*, *Omega: the Journal of Death and Dying*, and *Journal of Family Therapy*. In early 2009 she was invited by the Road Victims Trust in the United Kingdom to act as an independent assessor of their application "Road death: The role of support in traumatic bereavement" to the Big Lottery Fund. Dr Breen has authored over 25 refereed papers and book chapters and has secured over \$300,000 in research funding. She is currently a member of The Australian Psychological Society and the Australian Centre for Grief and Bereavement.

Dr O'Connor is a Senior Research Fellow in the WA Centre for Cancer and Palliative Care, Curtin Health Innovation Research Institute, Curtin University. Dr O'Connor's programme of research focuses on psycho-social aspects of cancer and palliative care, children of women with a cancer diagnosis, supports and interventions for carers, and bereavement. To date Dr O'Connor has authored over 30 refereed papers and book chapters and has secured over \$1,000,000 in external funding. Dr O'Connor was a chief investigator for a multi-site national Pharmacy Guild of Australia funded project that investigated enhancing the role of the community pharmacist in palliative care. This project informed policy and practice, and led to education modules for community pharmacists and a model for accredited pharmacists to conduct medication management reviews for palliative care patients. Dr O'Connor is also a chief investigator on collaborative grants in the areas of communication and information needs of patients, carers' support needs and support after bereavement. Many of these collaborative projects have been in response to identified needs and gaps in the community.

Dr Le is an Associate Professor in Economics in the School of Economics and Finance at Curtin University. Her research interests centre on applied labour economics. She has published in a range of journals, such as *Industrial & Labor Relations Review*, *Applied Economics*, *Scottish Journal of Political Economy*, *Economics of Education Review*, *Education Economics*, *International Migration Review*, *International Migration*, *Journal of International Migration & Integration*, *Journal of Economic Surveys*, *Economic Record*, *Australian Economic Review*, and *Australian Economic Papers*.

Ms Clarke is a Research Nurse at the WA Centre for Cancer and Palliative Care, Curtin Health Innovation Research Institute, Curtin University. Prior to embarking in research, Jenny was an experienced Oncology and Haematology Registered Nurse. Recent research project work includes working as a clinical trials co-site co-ordinator for the Palliative Care Clinical Studies Collaborative; long-term involvement with "Dignity Therapy-An intervention" to relieve psychological distress and enhance dignity for terminally ill patients; and the Consumer Impact study, which involved the development of consumer impact statements relating to patient and carer end-of-life experience.

Appendix B: Project Timeline

October – November 2010

Phase 1 – Ethics clearance from Edith Cowan University; formation of the stakeholder reference group; first meeting of stakeholder reference group; develop data collection protocols

January-May 2011

Made additions to the stakeholder reference group; ethics clearance from Curtin University;
Phase 2 – Documentary analysis of interstate services and telephone interviews with key personnel

June 2011

Second meeting of stakeholder reference group

July-August 2011

Phase 2 (continued) – Visit interstate road trauma support services for interviews with staff and observations of premises, resources, and service delivery
Phase 3 – Report writing and dissemination

September 2011

Dissemination of draft report to stakeholder reference group for feedback
Third meeting of stakeholder reference group
Final report completed and provided to Department of Health (WA) and members of the stakeholder reference group

Appendix C: Stakeholder Reference Group Meetings Notes

First Road Trauma Support Reference Group Meeting

Date: Tuesday 30th November 2010

Venue: ConnectGroups, 335-337 Pier Street Perth

Start: 9.30am

1. Welcome
2. Apologies: Merle Taylor, Steele George, Odwyn Jones, Peter Farnham, Barry May (WA Police), Danny Mosconi (Fire and Emergency Services Authority), Gary Cooper (Office of the State Coroner), Corinne Moulé (WA Police), Allyson Browne (Royal Perth Hospital)
3. Present
 - a. Colleen Fisher – told personal story of bereavement and wants support to be available for everyone involved/affected by road traffic crashes.
 - b. Angela McDowall (coordinator of PARTY programme at Royal Perth Hospital) – commented that there needs to be more than education of the young because all demographics are involved in road crashes.
 - c. Marianne Carey (RAC) – her focus is vulnerable road users.
 - d. Benny Sullivan (Public Health Advocacy Unit, Curtin University) – coordinator of the Healthy Roads Project.
 - e. Chris Parry (Department of Indigenous Affairs) – described his history of working at Roadwise and Main Roads and his personal history of being a bereaved parent and volunteering as a counsellor at SIDS and Kids.
 - f. Sharon Easton (Emergency Department, Swan Districts Hospital) – spoke of her former work as a bereavement social worker at RPH.
 - g. Sam Sita – shared his personal story of bereavement and is a counsellor at Lifeline (representing himself, not Lifeline).
 - h. Jenny Bergman and Carole Macey (Victim Support Service, Department of Justice) – the Victim Support Service has a limited ability to support people affected by road crashes because the support is offered only when a charge is laid.
 - i. Antonella Segre (ConnectGroups) – is aware of the lack of ongoing support services, has a grant to look at Indigenous needs as well.

- j. Susanne Bahn (Edith Cowan University) – a researcher on the project with background in occupational health and safety and safety generally.
 - k. Terri-Anne Pettet (Roadwise) – Roadwise’s focus is primary prevention, spoke of previous funding from their community grants scheme, which funded a support project through Lifeline.
 - l. Don Sonsee (Chaplain at St John’s Ambulance) – described ambulance services at the frontline of road traffic crashes.
 - m. Glenda Maloney via telephone – spoke of her personal story of bereavement and advocacy for support services in WA. She reported there are current attempts to get legislative changes so that money from the Road Trauma Trust Account can be used for post-crash services and supports. She stated she would like something in WA like the Road Trauma Support Team in Victoria which is a stand-alone, comprehensive service that is free.
 - n. Barb Rawlins – spoke of her personal story of bereavement and has had contact with the Road Trauma Support Team in Victoria.
 - o. Lauren Breen (Edith Cowan University) – lead researcher in the project.
4. Overview of the project
- a. Lauren disseminated the project proposal (funded by the Department of Health), provided a verbal summary, and asked for feedback during the meeting and welcomed further feedback via email.
 - b. Terri-Anne and Antonella noted that a key issue concerns where to access funding for the service, as it is not likely to be useful to propose a model if there is no money to fund it.
 - c. Terri-Anne suggested we keep an open mind regarding funding options rather than banking on being able to access money from the Road Trauma Trust Account.
 - d. Glenda stated that the Office of Road Safety, Road Safety Council, and the Ministerial Road Safety Council have all signed off on this project and therefore it could be argued that funding come from the Road Trauma Trust Account. She cited the Road Trauma Trust Account’s annual budget and said that a service like the Road Trauma Support Team in Victoria would only require very small proportion of the money. Her perspective is that we/the project should push for this legislative change rather than having fragmented services funded from different places.
 - e. Sharon spoke of the importance of having families contacted immediately and linking them with and/or providing them with information on appropriate services.

- f. Antonella put to the group the idea of helping to set up a support group for victims, as a start. Glenda expressed concern that the government might then see the entire need as supplied by the group and would then not fund a full service.
 - g. Sue commented that having university researchers leading the project means that any recommendations from the project might have more weight than individual voices.
 - h. Carole commented on documenting the needs of people in the community and how they might be met by a service or supports. [NB: Lauren and Sue discussed this point after the meeting and agreed that the information needs of key groups – bereaved, injured, first responders, witnesses, offenders etc. – will be outlined in the report, as will current services and gaps in WA].
 - i. Colleen asked for clarification of the role of the reference group and Lauren described how she sees the group as guiding the project. Colleen offered her services in a volunteer capacity to work on the project. Lauren and Sue stated they would discuss this offer with her after the meeting. [NB: This discussion occurred after the meeting and it was decided that Colleen will remain on the reference group only].
5. Next meeting
- a. Lauren reported that the next meeting will likely be in February and will be organised via email. She will attempt to provide more notice/a greater lead-up time.
6. Close – 10.45am

Second Road Trauma Support Reference Group Meeting

Date: Tuesday 28th June 2011

Venue: ConnectGroups, 335-337 Pier Street Perth

Start: 9.30am

1. Welcome
 - a. Present: Lauren Breen (Curtin University), Terri-Anne Pettet (Roadwise), Cath Ferguson (Edith Cowan University), Antonella Segre (ConnectGroups), Rob Kingma (Fire and Emergency Services Authority), Odwyn Jones, Benny Sullivan (Curtin University), Alan Maloney, Colleen Fisher
 - b. Apologies: Carole Macey (Victim Support Service), Deborah Costello (Injury Control Council of WA), Angela McDowall (Royal Perth Hospital), Richard Higgins (Paraplegic Benefit Fund), Corinne Moulé and Barry May (WA Police), Marianne Carey (RAC), Stephanie Fewster (Carers WA), Don Sonsee (St John Ambulance), Sam Sita, Sharon Easton (Swan Districts Hospital), Allyson Browne (Royal Perth Hospital), Chris Parry (Indigenous Affairs), Diana Elliot (Sir Charles Gairdner Hospital), Christina Wright (People with Disabilities)
2. Update on the project and progress so far
 - a. Lauren provided an overview of the reasons behind the delay in the project (originally scheduled for completion June 2011) – the main issue was that the funds were 'lost' at the university and she's only had access to them since 14th June. Consequently, the Department of Health has agreed to an extension to the deadline. Lauren presented a draft amended timeline, which was discussed and supported. The amended timeline outlines the following key deliverables and dates – dissemination of draft report to reference group for feedback (2nd September), third (and final) meeting of reference group (20th September), and final report completed (30th September). Antonella suggested we try to get a longer extension but aim for the timeline presented. This idea was supported.
 - b. Lauren provided an overview of the sections of the report (the draft Table of Contents was circulated). The consequences of road traffic crashes are included, as emphasised by Carol Macey at the first meeting. There are also sections devoted to current services available in WA and the efficacy of support interventions for trauma and bereavement.
 - c. Case studies of services elsewhere in Australia were discussed (this document was circulated via email prior to the meeting).
 - d. Lauren provided the 12 points that the Department of Health wants included in the report (these are below):
 1. recommended road trauma support roles and services and evidence supporting their effectiveness (including a review of interstate road trauma services);

2. preferred options and recommendations to establish sustainable road trauma support service in WA, including possible service providers;
3. options to facilitate the delivery of accessible peer support and professional counselling across metropolitan and regional WA;
4. recommended mechanism to advertise and to promote road safety peer support services state-wide;
5. the scope, extent and duration of cost-free support for victims, offenders, witnesses, family and friends and other community members;
6. criteria for selecting, training and appointing professional and peer support counsellors as required;
7. the extent and delivery of associated advocacy, research and road safety education roles;
8. resource requirements, including accommodation, administration, computing, communications and promotional materials;
9. estimated costs associated with establishing and sustaining recommended road trauma support services in WA, and recommended funding providers;
10. stakeholder details and contacts, including government, non-government organisations, industry and community groups;
11. an evaluation and reporting framework to monitor, assess and provide constructive feedback on the effectiveness of the WA road trauma support service, on an ongoing basis; and
12. an outline of essential steps to ensure the successful introduction of sustainable road trauma support services across WA.

3. Discussion

- a. A discussion ensued concerning what do we still need to know, which service(s) should be visited, and what else needs to be included in the report? The group unanimously recommend that Lauren visits the Road Trauma Support Service (Victoria), and at least one of the following state's services – Tasmania, South Australia, or Queensland – dependent on timing, logistics, and funds. Terri-Anne suggested that visiting an established and less-established service would provide insight into the variables that are required for success. For example, if other services are struggling because of funding, we'd need to recommend sustainable funding so that the WA service doesn't fail for this reason.
- b. Odwyn suggested the need to investigate different funding sources for the service. Suggestions from the group included Insurance Commission of WA, other insurance companies, mining companies, the Department of Health, and the Road Trauma Trust Account. Terri-Anne and Lauren reminded the group that funding from the Insurance Commission is fraught by the fault system in WA, and that legislation would need to change if the funding was to come from the Road Trauma Trust Account (Currently, the funds can only be used for prevention of road crashes). Antonella suggested that, if a mix of funding is sought, that we don't get too much commitment from non-government sources because then the

government won't see a need to fund it – there is a need for recurrent funding, not a one-off grant.

- c. Cath also said that the service could charge for services that are not for direct clients e.g., workshops.
 - d. Antonella said that ideally, the service should be comprehensive and collaborate with existing services and supports. She also said the report should specify, as much as possible, the recommended staffing, programmes, and so on, so that the report can act as a blueprint for the design and organisation of the service.
 - e. Colleen reinforced the importance of the promotion of the service so people in need know where to go to get assistance.
 - f. Rob reinforced the idea that the service needs to be flexible to meet individual needs.
 - g. Lauren presented feedback from Chris Parry, who suggested that, in order to gain a more complete understanding of grief support, other service providers could be researched in terms of logistics, complexities, innovations and so on. He mentioned SIDS and Kids, Survivors of Suicide, Lifeline, Samaritans, and CanTeen. This proposal was discussed. The group decided that, due to the projects timeline and funds, the report should focus on road trauma organisations.
4. Next meeting
- a. Lauren suggested the next (final) meeting will be two hours in duration and should be on Tuesday 20th September. The aim will be to discuss the draft report and recommendations (Lauren will circulate the draft report on 2nd September).
 - b. Venue TBA, but will be somewhere central with disability access e.g., Department of Health or Carers WA/ARAFMI.
5. Close 10.50am

Third Road Trauma Support Reference Group Meeting

Date: Tuesday 20th September 2011

Venue: Carers WA, Lord Street Perth

Start: 9.30am

1. Welcome
 - a. Present: Lauren Breen (Curtin University), Terri-Anne Pettet (Roadwise), Antonella Segre (ConnectGroups), Jonine Kehoe (ConnectGroups), Rob Kingma (Fire and Emergency Services Authority), Odwyn Jones, Benny Sullivan (Curtin University), Alan Maloney, Glenda Maloney, Colleen Fisher, Matt Brown (RAC), Deborah Costello (Injury Control Council of WA), Stephanie Fewster (Carers WA), Paul Davis (Carers WA), Don Sonsee (St John Ambulance), Sam Sita, Sharon Easton (Swan Districts Hospital), Diana Elliot (Sir Charles Gairdner Hospital), Richard Higgins (Paraplegic Benefit Fund), Amber Arazi (People with Disabilities).
 - b. Apologies: Marianne Carey (RAC; Matt Brown attended as Marianne's proxy), Cath Ferguson (Edith Cowan University), Corinne Moulé (WA Police), Allyson Browne (Royal Perth Hospital), Barb Rawlins
2. Overview of the report
 - a. Lauren presented an overview of the draft report (disseminated weeks earlier) and invited group members to make comments and suggestions.
3. Discussion of report and recommendations
 - a. There was some discussion about the history of the project and where it was funded, and it was suggested that some of this could be added to the report's executive summary.
 - b. It was suggested by Jonine, Cath (who emailed her suggestions), and Stephanie that there should more on information on the effects of injuries and that there are separate sections for the effects on people who are injured and the effects on their families, friends, and carers. Stephanie and Paul also suggested that the terms carer or unpaid family carer are preferable to caregiver.
 - c. As Carers WA is the peak body representing carers, it should be incorporated into the section describing the current supports and services that are relevant to road traffic crashes in WA. Lauren will liaise with Stephanie for this.
 - d. It isn't immediately clear from the report that Lifeline no longer has a road trauma counselling service – this section requires clarification.
 - e. While the report says that gaps for psychotherapeutic services tend to range between \$33 and \$39 per session, there was the suggestion that the report

also needs to show that the out-of-pocket expenses may be considerably more.

- f. There was some suggestion that the limitations and gaps of the current context needs to be 'beefed-up' so that the limitations and gaps are expressed more clearly. Some members of the reference group (e.g., Jonine, Glenda, Colleen) shared their experiences of negotiating services and highlighted the limitations of and gaps in the current system.
- g. Diana and Paul expressed their reservations about the tenor of the section outlining trauma and bereavement interventions; the sections requires further contextualisation as it reads as being too medicalising and pathologising with too much focus on disorders and not enough acknowledgement of other approaches.
- h. It was suggested that, in the section describing the road trauma support services in other states, a table summarising their strengths and limitations would be helpful.
- i. There was some discussion about the length of the report and whether and how this might be addressed. Lauren stated that has considered writing two reports – a long version with everything and a shorter version that is more readable but that she needs to be guided by the Department of Health.
- j. Odwyn suggested the incorporation of state and national road safety strategies to the report.
- k. Matt suggested Lauren consider amending the use of emotive language in the recommendations (e.g., must, should) and Stephanie suggested these words be removed altogether.
- l. Terri-Anne described an email conversation she'd had with Lauren about distinguishing between the recommendations (as authored by the researchers) and the role of the reference group. There was some discussion about this distinction and Antonella provided an excellent explanation. It would then be up to organisations to decide whether to endorse the report and its recommendations.
- m. There was quite a bit of discussion about the funding options. Matt explained that the legislation underlying the Road Trauma Trust Account precludes the use of these monies in post-crash supports. Glenda shared correspondence she has received from MPs suggesting the possibility that the Road Trauma Trust Account could be used to fund a road trauma service and Lauren stated that the Road Trauma Trust Account funds have been used in the past for post-crash supports. Matt shared his concerns about 'shutting the door' to other options if only one is outlined in the report and suggested Lauren contact the Office of Road Safety about the latest legal advice on the

legalisation (Lauren will follow-up on this). Antonella suggested that use of the Road Trauma Trust Account is the most obvious source but that other funding options should be considered in the report. Discussion ensued about the possibility of mixed funding from various sources such as health, mental health, Royalties for Regions, etc., with the idea to have recurrent funding. Amber suggested the possibility that a separate Government fund be established.

- n. There was quite a bit of discussion about whether or not fees should be charged, relative to income, for the professional psychotherapeutic interventions, with some members suggesting that asking about income could be offensive and impractical, and that these negatives would outweigh any potential income that would be raised.
- o. It was suggested that Lauren clarify the workshop fees for offenders i.e., pay a fine or complete the workshop in order to have a driver's licence reinstated.
- p. Glenda shared that she'd been contact with Dr Fiona Wood, Injury and Trauma Network, who is waiting for the report. Both Glenda and Antonella thought that Dr Wood would make an excellent patron of the road trauma support service.
- q. Matt queried the size of the proposed Board of Management, given the small number of paid staff, and Antonella explained that this ratio was common and advantageous in the non-government sector.
- r. Antonella and Jonine spoke of the importance of adding Indigenous Australians/Aboriginal and Torres Strait Islander Australians to Recommendation 21.
- s. Lauren stated that she would disseminate the meeting notes as soon as possible and finalise the report, as it is due to the Department of Health on the 30th September. She will also find out if the Department still would like her to deliver an oral presentation to the Road Safety Council.

[NB: The meeting extended beyond the advertised time so some people left, from 11am onwards]

4. Acknowledgements

- a. Lauren acknowledged and thanked the reference group for its commitment to the project. She stated that some members of the group were not affiliated with any organisation and were therefore not being paid for their attendance and were paying their associated expenses (e.g., petrol, parking). These group members will receive a voucher to acknowledge their time and effort.

5. Close – 11.45am

Appendix D: Structured Protocol for Data Collection

The purpose of this interview is to find out road trauma support services here at [organisation].

First, I'd like to find out a bit more about you:

- Can you tell me about your background and experience in road trauma support services?
- Can you tell me about your job and duties or activities here at [organisation]?

Now I want to move on to talking about this organisation:

- Can you tell me about the history of the organisation? What was the impetus for the service? How has it developed over time?
- What were the set up costs and how were these funded? What are the annual costs? Where do you access funding now?
- What resources are required to run the service? (accommodation, administration, computing, communications and promotional materials, etc.)

Now I want to move on to talking about the services offered here:

- Who to you provide services to? Inclusion/exclusion criteria? (gender, Indigenous status, and cultural and linguistically-diverse status of clients; how many, including total client numbers and breakdown for bereaved, injured, witnesses, and others)
- How long do you provide services?
- What fees are charged?
- How do you recruit, train, and appoint staff? (Professional counsellors and peer supporters)
- How are people referred here? Do you refer to other services? If so, where and when?
- How do you promote the services to potential users and to referring professionals?
- Do you provide additional services such as advocacy, research, and road safety education?
- Do you offer metropolitan as well as regional service delivery? If yes, are these the same or different? How so?
- How are the services evaluated? How do you know they are effective? What would you like to see incorporated into the service? What could be improved?
- What do you think has contributed to the success of the service? What has contributed to any setbacks?
- What advice do you have to setting up a road trauma support service in WA? What should be focussed on and what should be avoided?

Thank you for participating in this interview today. Your answers have been really helpful in understanding your road trauma support service.

- Are there other questions you wished I had asked you or anything else you wish to talk about?

Thank you for your time.

