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BARRIERS TO FRONTLINE MANAGER SUPPORT FOR HIGH-TRAUMA WORKERS

INTRODUCTION

The nature of emergency services work exposes paramedics to extreme events as a regular feature of the role (Bigham et al., 2014; McFarlane, Williamson, & Barton, 2009). Chronic exposure to trauma increases the risk of mental health problems such as depression, anxiety, high-risk alcohol and drug use, and post-traumatic stress disorder (PTSD) (Bennett et al., 2005; Grant, Dutton, & Rosso, 2008; Huizink et al., 2006; Izutsu, Tsutsumi, Asukai, Kurita, & Kawamura, 2004). PTSD in particular has been noted as particularly high among paramedics, even in comparison with other emergency services personnel (Drewitz-Chesney, 2012). Therefore, in this work environment, management of individuals exposed to trauma, and support provided by key persons, is critical.

Deterioration of mental health has a significant impact on organisational performance. Mental health problems are associated with declining employee health and wellbeing (Berger et al., 2007), increased burnout and long-term absences (Brattberg, 2006), and ultimately, greater employee turnover (Patterson et al., 2010). It is well accepted that organisational

factors can influence the prevalence and severity of such problems, and promote improved outcomes. For example, evidence supports the positive influence on health and wellbeing of formal support systems such as professional counselling and resilience training (see for instance, Richmond, Pampel, Wood, & Nunes, 2017) and programs whereby peers are trained to provide counselling and support to one another (Revicki, Whitley, & Gallery, 1993; Scully, 2011). Relationships with colleagues and frontline managers (FLMs) can also be instrumental in reducing the severity of symptoms and encouraging positive post-traumatic growth (Oginska-Bulik, 2015; Prati & Pietrantoni, 2010; Somville, De Gucht, & Maes, 2016). Frontline managers, in particular, play a key role in support provision. This could be simply engaging in emotionally supportive dialogue, advising formal support pathways, or moving an affected employee to a different role.

This article investigates the role of, and barriers to, support provided by FLMs to employees exposed to frequent work-related trauma. Specifically, we seek to identify and understand barriers that prevent FLMs from providing the type, quality and quantity of support employees require. Support is conceptualised as a multifaceted construct comprised of four key types (House, 1981), and the FLM is in a unique position to address all four employee support needs. Drawing on data from a three-case Australian study conducted in the emergency service sector, three categories of barriers to provision of optimal employee support are identified, specific to the FLM themselves, the workplace, and the employee. Under each category we expand on the nine barriers to support and investigate how these barriers can individually or in combination prevent one or all types of employee support from being provided or received. First though, this article brings together previous research on high-trauma workplaces, social support, and FLMs.

HIGH-TRAUMA WORKPLACES

Fire fighters, military personnel, emergency nurses, police officers, and ambulance workers all work in environments characterised by high stress and frequent exposure to extreme and traumatic events. Work in such fields can be complex, unpredictable, time pressured, high risk, and involve human suffering. As noted, exposure to work of this kind is inextricably linked with increased prevalence of mental health conditions (Bennett et al., 2005; Grant et al., 2008; Huizink et al., 2006; Izutsu et al., 2004).

For ambulance workers, research details other job-related factors that compound the effects of an already challenging role. Aside from vicarious trauma associated with exposure to, or involvement in extreme events, ambulance workers are at risk of physical and psychological injury. At least half of ambulance workers have been physically assaulted (Gabrovec, 2015), and 90 percent have been exposed to some type of violence (Pourshaikhian, Abolghasem Gorji, Aryankhesal, Khorasani-Zavareh, & Barati, 2016). One of every four have also been sexually harassed or assaulted at work (Bigham et al., 2014; Pourshaikhian et al., 2016). On the whole, the risk of serious injury for ambulance workers is seven times higher than the Australian national average, and the fatality rate is six times higher (Maguire, O'Meara, Brightwell, O'Neill, & Fitzgerald, 2014). In combination, such factors contribute to a high-trauma work environment where support is necessary to reduce the incidence and severity of employee mental health problems.

DECONSTRUCTING SOCIAL SUPPORT

It has been long established that lack of social support is a causal contributor to physical and psychological wellbeing (Blau, 1981; Cohen & Wills, 1985; Halbesleben, 2006). The term ‘social support’ is often used broadly to capture ‘any process through which social

relationships might promote health' (Cohen, Gottlieb, & Underwood, 2000: 4). Specifically, social support is the provision of psychological and material resources by the social network to the individual, intended to improve an individual's ability to manage stress (Cohen, 2004). This article focuses on the social support provided by FLMs and its effects on employees in high-trauma workplaces. Although we refer to more formalised support systems in the findings (e.g. employee assistance programs, external psychologists), this is secondary to the focus on social support provided by the FLM.

The pathway from social support to improved wellbeing has been described in early research as having a multi-pronged effect on the individual (Cohen & Wills, 1985). First, it has an immediate *buffering effect* of lessening the impact when a person is subject to a stressful situation. Second, accumulation of social resources and integration in a social network acts as a *protective mechanism* and leads to improved well-being over time. These two processes of social support have important implications for high-trauma workplaces such as those faced by paramedics in lessening immediate and ongoing implications of trauma exposure, and improving wellbeing.

Social support can be provided by many individuals in the employee's network, including friends, partners, family, colleagues, and FLMs. The support provided by two individuals - a spouse and a FLM for instance - is unlikely to be perceived as meeting the same needs by the employee. It is important, therefore, to distinguish between the *types of support* individuals can provide. There are a number of well-established frameworks by which to categorise types of support (see for example, Barrera & Ainlay, 1983; Cohen & Wills, 1985). In this article, we draw on the seminal work by House (1981) which provides four types of social support, and

has been shown in the literature as effectively capturing the common terms used within many other support typologies (Malecki & Demaray, 2003: see page 233 for this analysis).

House's (1981) typology includes the following support types: *emotional* (kindness, trust, respect, love and empathy), *informational* (technical information or advice), *appraisal* (evaluative feedback and learning) and *instrumental* (provision of time, services, resources or financial aid). Support providers can facilitate provision of one type of support, such as empathy and care given by a spouse, or multiple dimensions, such as empathy combined with financial resources and physical support. Table 1 provides examples of how the FLM can facilitate each of these types of support (the FLM is the selected support person as they are the focus of the study).

[Insert Table 1 around here]

It is valuable to consider support as a multifaceted construct. Specific support types are often associated with certain sources (i.e. parents providing emotional support), and the effect of support can also depend on the type/s of support an individual receives or does not receive (Malecki & Demaray, 2003). For example, the emotional and appraisal support provided by peers is considered important for post-traumatic growth (Oginska-Bulik, 2015; Prati & Pietrantoni, 2010; Somville et al., 2016). However, for many paramedics, there are growing impediments to peer support such as increased workloads and hence, less downtime to defuse and support one another following a traumatic event. Accordingly, the need for emotional and appraisal support may have to be shifted to other people.

Family and friends may be available to provide support to trauma workers but some frontline workers indicate they often distance themselves emotionally from spouses and family members owing to the nature of the events they encounter at work. Evans, Pistrang, and Billings (2013) explain that support interactions with family are inhibited by the support-seeker omitting traumatic details to shield loved ones from experiencing a negative emotional response. FLMs can arguably be a more suitable source of support than family for discussing traumatic work experiences, and this support relationship is conducive to reducing the severity of post-traumatic symptoms (Oginska-Bulik, 2015). However, employees engaged in trauma work still prefer support from colleagues or family over FLMs (Somville et al., 2016), and it is deemed 'support from co-workers, compared to support from supervisors, has greater importance' (Oginska-Bulik, 2015: 119). This is concerning as FLMs are well placed to provide all four types of support (as detailed in Table 1). Given the nature of the work (clinical care and complex decision-making processes), there are circumstances whereby some types of support could not be provided by anyone in the network *except* the FLM.

Having established the importance of support from FLMs at work this article seeks to identify barriers that prevent employees *seeking* support from their FLM, and barriers that prevent FLMs *providing* support to employees. The next section outlines the FLM and locates this role in the ambulance service context, where it would typically be deemed the Station Manager.

THE STATION MANAGER

The FLM is typically directly responsible for day-to-day running of the ambulance station and staff. In regional and remote areas, many stations are manned by a single responder who is the manager but does not have a team. This cohort is not addressed here. Rather, we are

interested in exploring the critical role of FLMs, also referred to as station managers, station supervisors, station officers, and officers in charge.

Across industries, the FLM role has evolved over recent years, and decentralisation of many management activities including HRM has seen a consequent increase in the breadth of responsibility devolved down the line (Hutchinson & Purcell, 2010; Kellner, Townsend, Wilkinson, Lawrence, & Greenfield, 2016). Poor results in HRM have been associated with implementation issues including deficiencies in FLM ability to effectively manage people (Bos-Nehles, Van Riemsdijk, & Kees Looise, 2013; Hutchinson & Purcell, 2010). Lack of training and development in HRM is compounded by heavy workloads and performance targets, whereby FLMs are not only lacking ability but also time to develop themselves or connect with employees (Bos‐Nehles et al., 2013; Kellner et al., 2016; Townsend & Hutchinson, 2017). Hence what tends to occur is softer managerial skills are undeveloped, and FLMs must muddle through – with negative consequences for themselves and employees (Townsend, Wilkinson, Bamber, & Allan, 2012).

Critically, in occupations such as healthcare and emergency services, the FLM role possesses another layer of responsibility – responding to and managing employee responses to trauma. Where employees are highly susceptible to mental health problems, the FLM requires well developed emotional and cognitive ability to provide support. This ability may be affected by a range of factors including capacity to connect emotionally, their own mental health, and workplace factors noted earlier such as access to training and availability of time and resources.

RESEARCH FOCUS

The remainder of this article focuses on this role of FLM as a key source of the four types of social support (as defined by House, 1981) for emergency services employees. This article acknowledges the importance of social support for workers exposed to trauma, while considering research indicating a preference for support from sources other than the FLM. Accordingly, the research objective is to identify barriers to provision of social support by FLMs to employees in high-trauma workplaces. Specifically, *this study seeks to identify and understand the barriers to provision of different types of support, and how these barriers affect support quality or quantity* (or, 'optimal employee support').

RESEARCH METHOD

Emergency services organisations in three Australian states participated in the study. The cases have the following pseudonyms: North Service, South Service and East Service. The services aid a significant cohort of the Australian population, across metropolitan, rural and remote areas. Combined, the services handle around one-and-a-half million cases each year, including emergency and crisis planning and response, pre-hospital patient care, and hospital and inter-facility transport.

East Service is the largest by area, followed by North, then South Service. North Service has very low population density, is mostly comprised of remote and indigenous locations, and the paid workforce is less than 200 responders. South Service is a more populous state with a moderate sized metropolitan city, many regional townships and a larger workforce of around 2000. East Service includes a large metropolitan capital city, and a combination or regional, rural, remote and indigenous populations, and employs around 4000 staff.

The research project included 1216 telephone surveys and 72 interviews, complemented by secondary documents. Surveys measured employees' experiences of work and lifestyle and health factors. Interviews provided better understanding of nuanced issues and participant experiences. Secondary data included organisational, HRM and employee support strategy and planning documents, policies, procedures, and independent assessor reports. This article draws upon qualitative data only as this is most suited to answering the research question.

Sampling strategy

Access to cases was via the associated industry union. Union access is appropriate as South and North cases have 99 percent union density, and East has 70 percent density (and growing). Senior Management provided authority and research support. A criterion sampling strategy was adopted for interviews (Saunders & Lewis, 2012), with the key criterion that participants were current employees or managers. Recruitment for employee interviewees was initiated by request from union newsletters and email.

Interview technique

A semi-structured interview protocol provided rich and descriptive data and captured the context surrounding the phenomena (Neuman, 2011). Seventy-two interviews were conducted with participants ranging from emergency dispatch officers, patient transport officers, paramedics, frontline managers, middle management, upper management, leadership, and union representatives. This number is at the upper levels of what Saunders and Townsend (2016) describe as adequate for qualitative research, and Appendix 1 presents our list of interviewee titles and interviewee numbers which are cited following quotes. This article draws most insights from employee and FLM interviews. Interviews typically lasted 60-90 minutes and were conducted by one of four members of the research team.

Data analysis

Analytical conversations were conducted regularly during data collection to make alterations to protocol, identify preliminary themes or categories, and examine relationships between themes. This process is a version of convergent interviewing; a technique advocated by Jepsen and Rodwell (2008) to improve internal, external and construct validity of qualitative data collection. Interviews were audio recorded and transcribed before content was analysed using NVivo.

Inductive coding was used to analyse data (Patton, 2015). This process involves reading and re-reading data and assigning keywords (categories) to passages of text to facilitate sorting and identification of themes. An ongoing process of creating, deleting, merging and dividing resulted in agreement of three defined themes and nine categories. After coding approximately twenty interviews, no further codes were developed, indicating theoretical saturation was reached. Randomly selected sections of coded data were cross-checked by team members throughout process to test internal reliability with a high level of consistency.

BARRIERS TO SUPPORTIVE SUPERVISION

Analysis showed three overarching categories and nine barriers as follows:

Frontline manager barriers: (1) Training availability; (2) Attitude and empathy; (3) Mental health

Workplace barriers: (4) Physical proximity; (5) Time restrictions; (6) Workload restraints

Employee barriers: (7) Status differences; (8) Relationship integrity; (9) Attitude

The findings suggest these barriers are inter-related, whereby one barrier can interact with, and effect other barriers. For instance, workload restraints can exacerbate the FLMs mental health, decreasing ability to provide emotional support. Or, FLMs lack of empathy may reinforce the employee's closed mindset, whereby they will not continue to approach the FLM for support. Compounding factors may create a vicious cycle where employee, manager and workplace are interacting in a negative way that allows only limited support to be provided. These interrelated barriers will now be discussed in turn, illustrated by interview excerpts.

Frontline manager-centric barriers to support

This article is about FLMs; hence they will be examined first and in most detail. Analysis indicated three key barriers prevented FLMs providing support of the type, quality and quantity employees required: limitations in managerial training, incongruent managerial attitude, and deteriorated managerial mental health.

Availability of managerial training

There was strong evidence the major obstacle to quality support across cases was lack of training for FLMs. In North Service, at the time of data collection there was no training for FLMs relating to managing critical incidents and employee psychological wellbeing. This deficiency came through strongly in the interview data, as the following quotes from North Service demonstrate:

> As a station officer I was given no training for peer support or mentoring or mental health concerns. … if [FLMs] ask, 'are you OK?' they've done their job, and they haven't… It's not a matter of just asking, 'are you OK?' [19]

> I've often thought or wished … as a team leader that we get some basic training on trauma counselling… You often have worked with these people for a long period of time and there's an element of trust or familiarity with you… The intent may never be for team leaders to be the first point of call for that trauma counselling, they just are [24].

The previous quote indicates FLMs can be a preferred source of informational support for employees exposed to traumatic events. There is also – in some but not all supervisory relationships - a degree of trust which could facilitate emotional support. FLMs however are not equipped with sufficient skills to support employees or identify when they are suffering mental health difficulties. In the South Service, management recognised training for FLMs in this area would be beneficial.

> There isn't a formal training program as such in that space. One of the things we have is … a team leader induction course… [which includes] how to manage behaviour, how to manage and have support, and how to have challenging conversations [59].

The training provided by South Service is a positive step towards equipping FLMs with skills and knowledge to provide more effective emotional, informational, appraisal and instrumental support to employees. In East Service, programs for FLMs were well established and achieving good results. The Operations Manager and Employee Support Managers from the East Service expand on their program:

> We invested a lot in supervision a couple of years ago - three or four years ago now - on the premise that frontline supervision is the first circuit-breaker for psychological support...[FLMs] generally, they didn't realise, that they had a responsibility for psychological wellbeing. They didn't realise that there was resources available to them.

> Since we've started doing the training we've now had over 350 per cent increase in managers accessing support [64].
>
> Since we've been doing the training we now get lots of managers that ring us up and go 'look, I'm not sure what to do with this', or 'the crew's just been to this terrible job'. A lot of the time we'll be saying, 'have you rung the crew and seen how they're going?' Sometimes it's about talking them through that because they're wanting to do the right thing and wanting to get us involved [65].

East Service was particularly proactive in developing a formal program of peer support, later emulated by services in other states. The program, open to volunteers who are both FLMs or employees in other roles, provides training and supervision in mental health education and micro-counselling skills. These peer support officers are often the first-line of contact, as they follow up with staff exposed to particularly difficult or traumatic events (for more details on such peer support programs see Scully, 2011, or 'The Road Home Wellbeing Program' supporting veterans and emergency services workers in Australia).

In sum, our data indicates a major barrier to providing adequate employee support of all types is possessing required skills. Availability of managerial training appears to be effective in developing managers to provide all four types of support to employees.

Managerial attitude and empathy

For some FLMs, it appeared emotional unsuitability or undeveloped emotional awareness/intelligence rather than lack of training was the fundamental barrier to providing emotional support. Across the three services, there was widespread discussion around individual FLM attitude, mindset or personality that prevented them from connecting and empathising with employees. A perceived lack of empathy for the employee was often

described by participants, such as a South Service paramedic who shared "sometimes I feel a bit that [FLMs] are disengaged from the human aspect of what they're doing… This will probably be a bit harsh, but they don't really care [43]." Interviewees demonstrated the type of behaviours and conversations which created the perception of a lack of empathy from FLMs, for example:

> 'If you are not tough enough get out of the job', this sort of thing. 'If you can't handle it get out. There's the door.' I've actually heard managers say that to people. I've been in earshot, saying, 'you can't do that. You can't say that. They need help!' [4].

> The lack of probably empathy from management… [Paramedics] just tried to revive a drowned child and they clear the hospital and they get told they've got to go on the next job. There's no time for them to sort of relax a bit for five or 10 minutes, just the next job. Their supervisors don't go, 'hey, how are you going?' First thing they say to them is, 'have you pushed your POS button [indicating they're ready for the next job]?' [49].

The last quote expands on the concept of a lack of empathy to suggest FLMs may feel they do not have capacity to display empathetic behaviours because of the nature of the work. Work intensification over past years has placed increasing pressure on paramedics and FLMs and this is particularly evident in the metropolitan stations. Although, as another paramedic from South Service suggests in the following quote, his experience of two metropolitan FLMs in the same city also points to a high degree of variation in communication skills and empathy:

> Oh, at [a city station] I had two team leaders, because I split between the two [stations], and they were polar opposites. One was very helpful and supportive. The other one

> was an elitist and didn't have any personal skills. Didn't know how to communicate with people. Apparently - well, not apparently - gave off the feeling he just didn't care [41].

It is difficult to determine from our study whether limited capability or emotional unsuitability creates this barrier to emotional support. There were however many examples of how this limitation played out in daily work of paramedics. Employees with a poor supervisory relationship could not access empathy, concern, encouragement and solidarity in the FLM relationship, and hence had to seek this support elsewhere:

> I went through a stage where we had a lot of very aggressive patients who were just incredibly abusive. When I mentioned that to my [FLM], her response simply was, 'well it must be you, you're the only one having these problems'… I found subsequent to our conversation was that most of my colleagues were having similar issues with their patients. They just weren't telling her about it. They were talking about it among themselves [21].

As the previous quote indicates, the need for emotional support, when not fulfilled by the FLM, can be fulfilled by others such as peers. However, there are other types of support where peers, family or friends are poor substitutes. A relationship weakened by poor emotional support will not be conducive to providing or receiving other types of support - advice, direction, discussion of options, technical feedback on cases, or referral to external services. Where the employee does not feel comfortable being emotionally vulnerable, this could also restrict conversations that may provide for instrumental support, that is, modification to the employment situation by the FLM. This could include changes to the workload or type of work, change of work partner, change to hours or roster, or arranging some leave. There are clear

consequences of a poor emotional support relationship that have flow on effects to other support types.

Managerial mental health

The final theme determined by our data analysis as a FLM-centric barrier to support was the mental health and wellbeing of the FLM themselves. A number of interviewees drew attention to the fact that FLMs typically have a long history of trauma exposure and are at risk of suffering themselves from PTSD or associated mental illnesses. The following quote provides a colourful example of how it can be difficult for FLMs to identify symptoms in staff when everyone is wearing the same 'shit coloured glasses'.

> If everyone's got shit coloured glasses on and you're all trying to look through the same lens… Your manager is that tainted as well by the job. They've got probably an underlying degree of PTSD and they can't see it in themselves either [29].

This perspective – that FLMs may struggle to provide support due to PTSD - also extended to other mental health problems and personal struggles that inhibit capability. The following paramedics from South Service note job-related stress and personal stressors affected the capability of their FLMs:

> If you say, 'look I'm not coping' then [the FLM] will make sure that you get any type of help that you need. Time off or assistance, getting down here or whatever. But he's got to be aware of it… you can see stressors in that job that affect him that he might not know, that he might not see himself [36].

FLMs struggle with the same issues from trauma exposure as employees, the effects of which can be exacerbated by personal issues. Their psychological wellbeing is shaped by long

periods of such exposure, and this is likely to affect their attitude and available empathy – demonstrating how these categories can be inter-related. This finding highlights the importance of peer support for FLMs within the structure of a strong employee assistance program.

Workplace-centric barriers to support

There are also factors specific to the workplace and environment that can inhibit employees and FLMs from fostering a quality support relationship. In all cases – but especially in the busier East Service – employees indicated physical proximity, time restrictions, and workload restraints were three major obstacles to support. There are complexities experienced by FLMs in different geographical areas, particularly associated with physical proximity between manager and employee. Despite differences between rural and metropolitan stations, lack of staff contact was still a common theme. A manager of a large region in the East Service describes this scenario:

> You talk to different officers in charge and the ones that look after a little station will say it's really hard because it's isolated and they don't see their staff much. Then the busier ones will say the same thing -that they're just so busy they don't get to see their staff [68].

The larger stations with high workloads face difficulties in building team and supervisory relationships. This is exacerbated - as the following quote confirms - by workload requirements of the FLM. Some creativity is required by FLMs to ensure contact with staff is maintained, and this middle manager explains how one FLM achieves this balance:

> It's hard because [a city-fringe station] is our biggest station for example, and they've got 70-odd staff… I want him talking to staff, I want him telling staff what's happening.

> So… he'll pop up to the hospital because that's where he gets to see them… and then you just watch how they communicate, see how they engage… it's all those non-verbals they're supposed to pick up [71].

The FLM role in the ambulance service involves a component of administration. Flexibility – in how the work day is spent and where – is essential to ensure the FLM can observe and interact with as many staff as possible. In some instances, however, FLMs were working typical office hours Monday to Friday, preventing adequate contact with staff. A Union Representative explained the detriment that set hours had on some employees in East Service, followed by a similar comment from a paramedic:

> You've only got the two [FLMs] who now [the organisation] have decided to put on managed hours, which basically means they're there from eight until four, Monday to Friday. Which I think is a real detriment to the crews… Their view is that [FLMs] are there to do the administration side of things [51].

> [FLMs] don't see the staff, they might see them at the start of a shift but they don't get access to the staff because of workload to do the welfare check and do it properly [2].

In sum, a number of workplace dependent factors inhibit FLMs from providing the desired support to employees. Physical proximity to staff at the right time, and availability from workload restraints, restrict FLMs and employees from building strong relationships and having the opportunity to give and receive support. These factors exist in most industries and are ongoing challenges that can be difficult to address fully, particularly given variations in location between work sites.

Employee-centric barriers to support

Establishment of a supportive FLM relationship is subject to active participation and willingness of both parties. There may be factors – real or perceived – that prevent the employee from engaging and connecting with a FLM in a way that allows emotional, informational, appraisal or instrumental support to be received. Factors identified here as employee-centric barriers to support - which arguably overlap with some FLM-centric factors discussed earlier – are the power differential of the relationship (brought about by the FLMs position in the organisational hierarchy), the employee's perception of relationship integrity, and the employee's own attitude, personality or mindset. Discussion of employee-centric factors was consistent across the three cases, although this category did not appear to be as critical a barrier as the FLM and workplace-centric categories.

Ambulance services, similar to police and military, have a traditionally hierarchical organisational structure with overt status differentials displayed openly on the uniform. For some employees, perhaps with a long career in the service, open communication with a FLM is not comfortable or is perceived unsuitable. An acting FLM explained:

> I've been doing this a long time and I am on the road but I also wear three pips on the shoulder. I can be empathetic but I'm not and in my role - you've got to talk to your level. A lot of people don't want to empty their heart out to me unless they know me [6].

As this interviewee indicates, there was a tendency to withhold and avoid emotional interactions with employees on other hierarchical levels. Although, there is evidence of change to status differentials over recent years and a less hierarchical culture is evolving.

Alongside the barrier created by hierarchy difference, there were some inhibitions about the integrity of private conversations where support was sought from FLMs. As one paramedic [21] from North Service stated, “There's no trust that you will get understanding, compassion, support or confidentiality. None of those is guaranteed.” Interviewees indicated that “not every manager, but definitely some managers, will turn on you if they know you are having trouble…” [14]. This alludes to the perception that admitting to suffering with mental health issues could be detrimental to an employees’ career.

The preference of participants to seek support from peers or family over FLMs was therefore deemed by many paramedics as a safer and more confidential source of support. It was also noted by a number of interviewees that peer support – over other sources of support – was very effective for receiving appraisal, that is, discussing the technicalities of a case and gaining feedback on performance.

> You might do a case that's very challenging, the guy in the car burnt, and you spend quite a few hours… All you really want to do is speak to your peers… It's not so much a case all the time of ‘oh I feel stressed’ or I think I'm emotionally challenged with it. It's more of… how you went professionally [34].

Where employees do not feel comfortable seeking feedback on their clinical performance from their FLM, this can be provided – where a strong relationship exists – from an employee’s peers. Finally, some interviewees also indicated an individual’s personality, attitude or mindset may prevent them from connecting with and receiving support from a FLM or others.

> I guess it depends on your … [FLM] as to how approachable they are. Our [FLM] is quite approachable… Whereas others don't feel that they're approachable and they would feel quite - they would need to [communicate] through a very formal process [61].

As with FLMs, some employees' attitude dictates it is not appropriate to seek support, particularly of an emotional type, from superiors in the workplace. Our interviews particularly indicated that this was more typical of employees who had been working with the service for a long time. Cultural change over recent times, combined with the shift to a younger and more tertiary educated cohort of newer recruits, has however sparked a shift in this mindset. These ongoing changes are likely to see a more open and accepting view of discussing mental illness and seeking support in this industry.

A model of the barriers to optimal employee support

The findings suggest nine barriers to optimal employee support, which can be placed under three categories as either FLM, workplace or employee-centric. Extending Table 1, which provided examples of FLM support for each of House's (1981) four social support types, Table 2 integrates the nine support barriers, and provides examples of how these barriers may restrict provision of each support type.

[Insert Table 2 around here]

As Table 2 demonstrates, there does not appear to be one particular category of barrier that is more or less pertinent to one support type. For all types, the FLM is the first barrier to support, as they are provider. There may be barriers to emotional support of poor FLM training or empathy for example that can be overcome, only to be met with workload restrictions that prevent time to meet with the employee. Such workload barriers may be overcome, only to be met with further resistance by the employee who questions the integrity of the relationship. This is a complex situation, better illustrated in a model, provided in Figure 1.

[Insert Figure 1 around here]

Figure 1 brings together our findings and Houses' (1981) typology to demonstrate the process of providing (and receiving) FLM support. On the outside we have the four support needs, which must pass through each layer, or category of support barrier, before reaching the employee (represented as the core). The FLM barrier must be overcome first, as they must have the capacity and desire to provide employee support. The FLM may desire to provide support, but they struggle to overcome the workplace barriers, then employee barriers. Only when all these barriers are overcome, is there an opportunity for employees to be supported emotionally, with information, appraisal and by instrumental means.

DISCUSSION

This article contributes to knowledge on managing employees in high-trauma workplaces, the nature of social support, and the evolving role of FLM. The findings help explain the types of support provided by different sources, and how the nine barriers affect provision of these support types, and the support quality and quantity. Theoretical and practical implications of these findings will now be discussed, concluding with limitations and recommendations for future studies.

Theoretical implications

Research consistently points to the important role of FLMs and the pressure placed on their performance by increasing devolution of HRM responsibility (Cunningham & Hyman, 1995; Hutchinson & Purcell, 2010). Such pressure was particularly evident in the findings of this study, where workload and HRM responsibilities are compounded by the need to consider, manage, and support employees with mental health problems. This support role for FLMs in high-trauma contexts however, has not been adequately explored in the literature. This

article begins a dialogue that clarifies the types of support the FLM can provide to a trauma-exposed workforce, and the barriers that need to be considered to ensure optimum employee support can be provided.

These findings also add to the ongoing discussion on the role of social support in reducing the effects of stress and trauma exposure (see for example, Oginska-Bulik, 2015; Prati & Pietrantoni, 2010; Wilkinson, Townsend, & Suder, 2015). Specifically, we adopt the view that it is valuable to examine the concept of social support through a lens that discerns support types (Malecki & Demaray, 2003). The FLM is unique in that they can service all the support needs of employees – emotional, informational, appraisal and instrumental needs (House, 1981), however, there exist significant barriers to this support provision. Juxtaposed against the barriers to FLM support presented in Figure 1, these two concepts make a new contribution to knowledge.

House's (1981) support needs framework is valuable in delineating types of support needed by employees. While we do not seek to directly apply this model and determine to what extent employees support needs are met, we are interested in explaining why employees do not receive as much support as they require from their FLM. The model of barriers to optimal employee support helps illustrate the findings and provide a map of the roadblocks to employee support. These findings are highly applicable to workers in other types of high-trauma workplaces and can inform research and practice for employees in Australia and internationally. Employees in these workplaces are not only of high risk of witnessing trauma to others, but of being exposed to traumatic and violent events directly, such as serious personal injury and harassment (Gabrovec, 2015; Maguire et al., 2014). These findings contribute to our understanding about the support needs of this cohort and may assist in

reconceptualising research that measures support among trauma workers, by uncovering greater nuance in the provision and receiving of support.

Practical implications

There are many practical implications arising from this study that may guide improvement of the support relationship between FLMs and employees in high-trauma workplaces. While some FLMs do provide emotional support, this seems contingent on their own emotional intelligence, mental health and mindset. Without a fundamental *emotional connection*, it seems that it can be difficult for employees to seek or receive *the other support types they need*. This may be information about formal support programs, appraisal of their performance in traumatic case, or instrumental support such as a temporary role change to recover from an episode of anxiety. Instrumental support is particularly important here, as it cannot be provided to the same degree from any other support source. Hence, we reiterate the importance of developing a FLMs capacity for emotional support, as a foundation to facilitate the other support types.

Providing all types of support is unlikely to come naturally to all FLMs. Training and development is critical to breaking down the barriers to quality support (Townsend, Wilkinson, Allan, & Bamber, 2012). An attitude of empathy is integral, and while it too can be learned through training, it can also be a criterion for recruitment. The emotional and psychological wellbeing of FLMs – typically tenured paramedics themselves – is another key consideration which may be overlooked in the workplace.

There is also a need consider the impact of hierarchical and status differences, which although they serve an important function in reliability focussed workplaces (Ericksen & Dyer, 2005), can be detrimental to building a culture of approachability and open communication about

mental health. While addressing such barriers is critical, peer support programs fill the gap when individuals are unable or unwilling to obtain support from FLMs. Formal support systems including peer support are becoming increasingly recognised in trauma work and scholarly research as particularly effective in minimising stress and the incidence of mental health conditions (see for instance, Revicki et al., 1993; Scully, 2011). Our findings can contribute toward development of the peer support model by highlighting the barriers which must be addressed to enable FLMs to play a more fundamental role as both a leader and a peer support person to their team. The aim for such programs should be for peer support to *complement*, not *supplement*, the support of FLMs.

Across states and territories, and even within them, there are stark differences in the characteristics of the ambulance service workplace, for example; station management styles, staffing demographics, geographical distances between teams, resourcing, and availability of training and support. Together with the state and territory-based differences in policies and procedures, the day-to-day mental health support available to emergency services workers (and trauma workers more broadly) varies considerable between individuals. Advice from policy-makers should be sought to provide a clear direction on how to address this concern, but from our findings we suggest there is a need for greater intervention and advice at a federal level to disseminate research knowledge and facilitate a more consistent approach to managing the mental health of high trauma workers.

Limitations and future research

The categorisation of barriers, when considered in conjunction with the support needs framework, are concepts applicable outside the context of the ambulance service. It is possible there is further complexity and that future research could identify additional barriers

not currently in the model presented here. Research could also address our limitations and strengthen the findings by examining barriers to support on a larger scale, across broader industries, or by survey development and administration. Further, given the issues relating to FLM mental health in our findings, we recommend future studies delineate FLM mental health from general employee populations to examine whether there are higher prevalence rates. Given the inadequacies and barriers to FLM support discussed here, there is certainly scope to focus more broadly on social support systems, and the formal organisational support systems, available for trauma workers. Finally, we recognise there is a need for further consideration of the practical application of these findings to trauma workplaces, and our study was limited to interviews only within organisations and associated unions. Future research could include higher- level interviews with policy makers and other key players in the industry to enable a broader and more holistic understanding of how we can continue to improve the experiences of employees, and their FLMs, exposed to trauma at work.

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Tables and Figures

Social support type	FLM support example
Emotional	FLM consoles, empathises with and expresses care towards employee who is distressed and anxious following a traumatic event
Informational	FLM provides advice on the how to access formal systems of support such as phone counselling or psychologist sessions
Appraisal	FLM appraises employees' decision making and clinical care in a difficult and traumatic case and reassures employee that correct action was taken
Instrumental	FLM arranges paid leave to aid recovery, and makes adaptions to the roster to ensure a gradual re-entry to work on lighter duties

Table 1. Examples of FLM support using House's (1981) Social Support Typology

Social Support Type	Example of support	Example of barriers preventing support
Emotional	FLM consoles, empathises with and expresses care towards employee who is distressed and anxious following a traumatic event	FLM has incongruent **attitude**; employee will not disclose due to **status difference**; FLM not regularly available due to **time restrictions** of limited office hours
Informational	FLM provides advice on the how to access formal support such as phone counselling or psychologist sessions	FLM **not trained** or informed of services available; negative **employee attitude** created by lack of emotional support
Appraisal	FLM appraises employees' decision making and clinical care in a traumatic case and reassures employee when correct action was taken	Employee doubts **relationship integrity** and does not disclose to FLM; geographic isolation limits **physical proximity** and prevents timely appraisals
Instrumental	FLM arranges paid leave to aid recovery, and makes adaptions to the roster to ensure a gradual re-entry to work on lighter duties	FLM does not consider options due to **heavy workload**; FLMs **mental health** hampers ability to support

Table 2. How barriers hinder the access of support

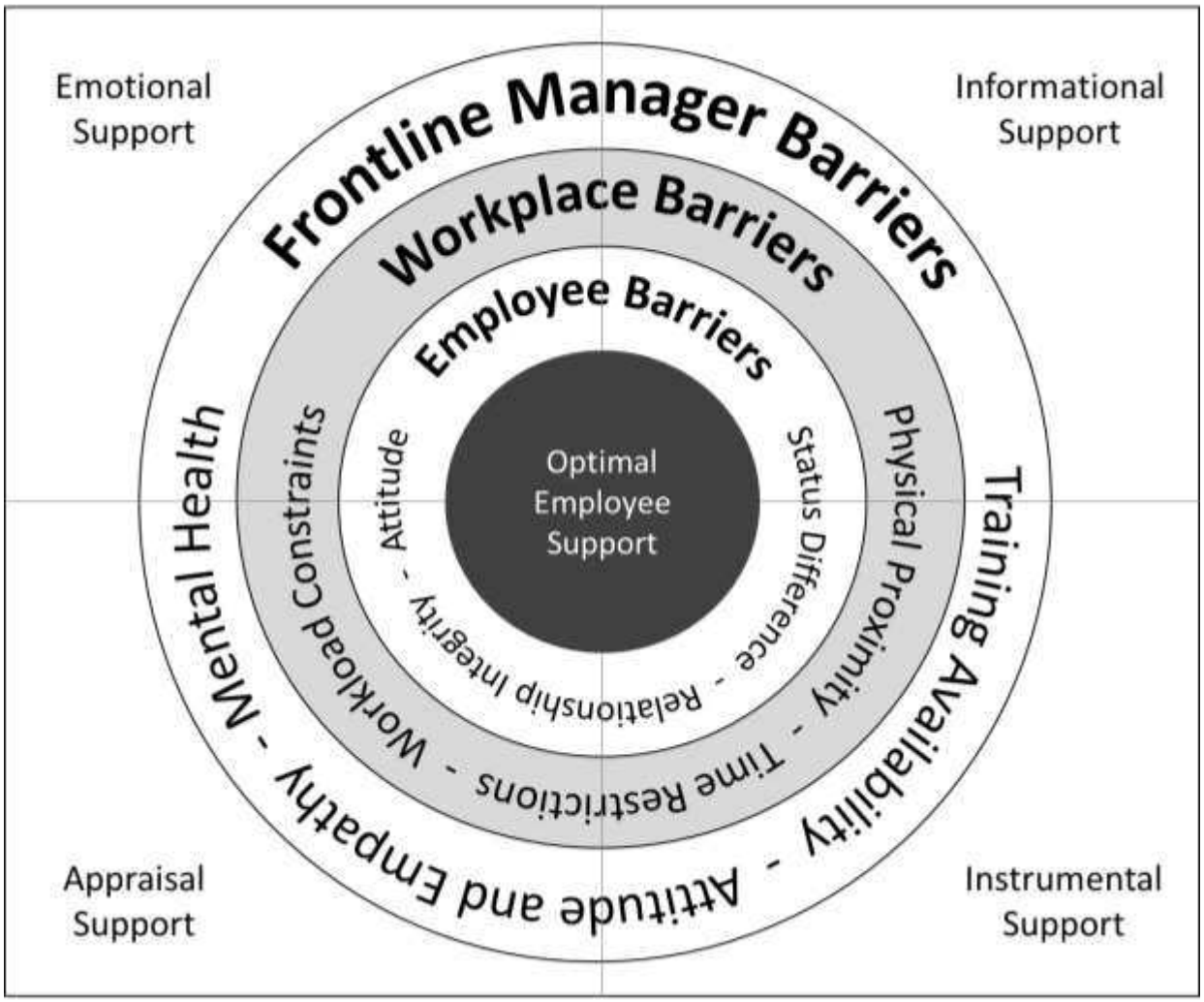

Figure 1. A model of the barriers to optimal employee support (adapted from House 1981)

APPENDIX

Interview 1 East Service, Frontline Manager	Interview 37 South Service, CEO
Interview 2 East Service, Paramedic	Interview 38 South Service, Paramedic
Interview 3 East Service, Dispatch Officer	Interview 39 South Service, Paramedic
Interview 4 East Service, Paramedic	Interview 40 South Service, Paramedic
Interview 5 East Service, Paramedic	Interview 41 South Service, Paramedic
Interview 6 East Service, Paramedic	Interview 42 South Service, Paramedic
Interview 7 East Service, Paramedic	Interview 43 South Service, Paramedic
Interview 8 East Service, Paramedic	Interview 44 South Service, Paramedic
Interview 9 South Service, Paramedic	Interview 45 South Service, Paramedic
Interview 10 East Service, Paramedic	Interview 46 South Service, Paramedic
Interview 11 East Service, Clinical Educator	Interview 47 South Service, Paramedic
Interview 12 East Service, Paramedic	Interview 48 South Service, Paramedics
Interview 13 East Service, Dispatch Officer	Interview 49 East Service, Union Rep.
Interview 14 East Service, Paramedic	Interview 50 East Service, Union Rep.
Interview 15 East Service, Paramedic	Interview 51 East Service, Union Rep.
Interview 16 East Service, FLM	Interview 52 East Service, Union Leader
Interview 17 East Service, Frontline Manager	Interview 53 South Service, Frontline Manager
Interview 18 North Service, Union Leader	Interview 54 South Service, Director Operations
Interview 19 North Service, Paramedic	Interview 55 South Service, Manager Ops.
Interview 20 North Service, Paramedic	Interview 56 South Service, Manager HR
Interview 21 North Service, Paramedic	Interview 57 South Service, Manager Ops.
Interview 22 North Service, Paramedic	Interview 58 South Service, Union Leader
Interview 23 North Service, Paramedic	Interview 59 South Service, Manager Ops.
Interview 24 North Service, Paramedic	Interview 60 South Service, Org. Psychologist
Interview 25 North Service, Paramedic	Interview 61 South Service, Paramedic
Interview 26 North Service, Manager Ops	Interview 62 East Service, Manager Clinical Ed.
Interview 27 North Service, Manager HR	Interview 63 East Service, Manager Clinical Ed.
Interview 28 South Service, Paramedics	Interview 64 East Service, Director Operations
Interview 29 South Service, Paramedic	Interview 65 East Service, Director Employee Support
Interview 30 South Service, Dispatch Officer	Interview 66 East Service, Director Finance
Interview 31 South Service, Paramedic	Interview 67 East Service, Director HR
Interview 32 South Service, Paramedic	Interview 68 East Service, Manager Clinical Ed.
Interview 33 South Service, Paramedic	Interview 69 East Service, Manager Clinical Ed.
Interview 34 South Service, Paramedic	Interview 70 East Service, Executive Director
Interview 35 South Service, Paramedic	Interview 71 East Service, Regional Manager
Interview 36 South Service, Paramedic	Interview 72 East Service, Director Planning & Perform.

Appendix 1. Interviewee number, case and role title