VICTORIA POLICE

# VICTORIA POLICE MENTAL HEALTH REVIEW

## AN INDEPENDENT REVIEW INTO THE MENTAL HEALTH AND WELLBEING OF VICTORIA POLICE EMPLOYEES.

Date: May 2016

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# Message from the Chief Commissioner of Victoria Police

I am passionate about the health, safety and wellbeing of our people.

I understand that policing is a challenging role. Our people are faced with difficult and complex situations on a daily basis. I am aware of the impact that this can have on our mental health at home, and at work.

My hope is that this Review will continue to raise the profile of mental health in our organisation. I want Victoria Police to have an inclusive culture where everyone feels comfortable to seek the help that they need.

There is no shame in acknowledging that you need help. It is not a sign of weakness. Mental health issues are indiscriminate and can manifest in different ways and at different points in people's lives.

Although the Review acknowledges that we have some way to go in improving employee wellbeing and reducing mental health risk, it highlights the good work that our internal health and support services have been doing in this area for some time now.

As a leadership team, we are committed to bringing about the necessary changes outlined in the Review. The mental health and wellbeing of our people must be a core focus for all leaders.

We look forward to working with our key partners in addressing the findings of the Review, including WorkSafe, The Police Association and the Community and Public Sector Union.

I would like to thank the Review Team for their work. I am confident that the recommendations will allow us to continue to build upon and fine tune our work, ensuring that we deliver a world-class service that protects the mental health and wellbeing of our people throughout their career and into their post-Victoria Police lives.

Finally, I would like to commend all those that contributed to the Review. The courage you have shown in sharing your stories with the Review Team has ensured the best possible outcomes for our people now and into the future.

**Graham Ashton AM,**
**Chief Commissioner**

# The Victoria Police Mental Health Review Team

## Dr Peter Cotton FAPS

Dr Peter Cotton is a Clinical and Organisational Psychologist specialising in occupational mental health and how organisational environments influence employee behavioural and wellbeing outcomes. He has published a number of book chapters and peer reviewed research papers, and works as an advisor to government and the corporate sector. He co-authored the 2014 Australian Public Service Commission and Comcare guidelines; *Working as One: Promoting mental health and wellbeing at work.*

Dr Cotton currently works as a Clinical Advisor with WorkSafe and Transport Accident Commission, Victoria, and also holds the following professional appointments: Workplace Mental Health Advisor with SuperFriend; and Member, beyondblue Expert Advisory Group on Mental Health at Work.

## Ms Nancy Hogan FACHSM

Ms Nancy Hogan has over 25 years of Board and Executive leadership experience across the health, aged care and superannuation sectors. Currently, Ms Hogan is Chair of Peninsula Health, Deputy Chair of Melbourne Primary Care Network and Deputy Chair of Victorian Healthcare Association; and an Executive Director, Health and Aged Care Services of Galante Business Solutions.

## Mr Peter Bull APM

Mr Peter Bull is a retired Superintendent who served in Victoria Police for over 39 years and worked across various work units before he retired in 2013, including; operational, corporate, training and service roles in both metropolitan and rural areas. He performed Government liaison and industrial relations duties and managed corporate projects, as well as managing a large station and several operational divisions.

Mr Bull is also a graduate of the Australian Institute of Police Management, a Williamson Fellow (Leadership Victoria) and was awarded the Australian Police Medal. Mr Bull was appointed to the Police Registration and Services Board (PRSB) in 2014.

## Ms Maryanne Lynch

Ms Maryanne Lynch is a professional writer and researcher who works across the community and arts sectors.

The Review Team acknowledges the particular assistance provided, over the duration of this project, by Katrina Blayney, VicPol Building Effective Workplaces Manager.

# Report Overview

The Victoria Police Mental Health Review commenced in November 2015. Since that time, the Review Team (Dr Peter Cotton, retired Superintendent Peter Bull, Ms Nancy Hogan, senior health sector executive; and Ms Maryanne Lynch, research assistant) have had over 450 contacts - via interviews, meetings and written submissions - with sworn and Victorian Public Service (VPS) employees at all levels and across all regions; retired members, partners and families of current and retired members; and families of deceased members.

The Review team also undertook an environmental scan to seek examples of relevant and emerging best practice internationally; and a rapid literature review of the global peer reviewed research databases. Additionally, key external stakeholders were consulted including Phoenix, beyondblue, the Australian Defence Force, Deakin Centre for Population Health Research, other police jurisdictions, The Police Association, Community and Public Sector Union and Police Legacy.

Key Mental Health Review findings include:

*Mental health and suicide risk profile and contributing factors*

- The current organisational mental health risk profile is significant but there is a lack of clarity around particular issues, including suicide risk. Hence a 'prevalence study' such as what was undertaken by the Australian Defence Force is indicated to establish a clear workforce mental health baseline profile and to assist in targeting and evaluating interventions.
- Post-traumatic Stress Disorder (PTSD) is not the only mental health risk: depression, anxiety disorders and substance abuse are just as, if not more, common.
- Whilst operational incident exposure is an important contributing factor to mental health risk, and can be cumulative, all evidence suggests that organisational factors (particularly leadership style, management practices, workload and resourcing issues) are also very important.

  The impact of operational incident exposure is significantly mediated by these organisational factors. This is also the case in relation to the risk for 'vicarious trauma', i.e., for members working with sexual abuse victims and online child exploitation materials.

  Another significant contributing factor that must be taken into account is personal relationship breakdown and family problems.

  Contributing factors interact in complex ways, i.e., personal relationship problems can be a major driver of the onset of mental health issues, or sometimes may actually be a consequence of the impact of other risk factors.

*Mental health stigma and Victoria Police culture*

- The Review Team identified the current key Victoria Police mental health and suicide risk challenge as involving how to address: member delayed help seeking when experiencing emerging mental health issues; and avoidance of any help seeking altogether, irrespective of the status of mental health symptoms. All of this was found to be a consequence of widespread and entrenched mental health stigma.

  Members delay appropriate help-seeking initially, due to under-recognition of warning signs in themselves and by others around them. Secondly, even when symptoms may be recognised, there is a reluctance to seek help due to a fear of detrimental impact on career prospects. Based on many interviews undertaken, the Review Team concluded that this fear has historically been well justified.

  To improve mental health outcomes, Victoria Police must validate and increase early help-seeking behaviour.

- At an organisational level, the Review Team found that Victoria Police currently has a relatively low level of 'mental health literacy'. Accordingly, there is an urgent need to implement an organisation-wide and comprehensive mental health literacy program.

*Why Victoria Police leadership culture needs to change*

- In addition to the organisation-wide mental health literacy program - and this is where the Mental Health Review Team findings resonate with and intersect with the Victorian Equal Opportunity and Human Rights Commission (VEOHRC) December 2015 Report – there are indications of a need for fundamental change in Victoria Police leadership culture. There are core organisation-wide weaknesses in 'people-focused' leadership capability that are also linked with an excessive tolerance bandwidth for bad behaviour at local workgroup levels.
- People-focused leadership capability is a mental health protective factor that operates through building supportive, cohesive and engaging team-based processes and practices. This type of team environment also buffers against the net impact of operational incident exposure. Increased organisational levels of people-focused leadership capability actually improve levels of employee wellbeing and reduce mental health risk.
- The Australian Defence Force has been on a parallel journey (dealing with sexual harassment, discrimination issues and mental health) and is more advanced, and has shown the way, in terms of recognising the need to change their leadership culture.
- Accordingly, a Victoria Police leadership culture change program is indicated, as VEOHRC has also concluded, to substantively increase the organisation-wide level of people-focused leadership capability. Without progress on the basis of such a program, any mental health-related initiatives will not gain sufficient traction, and will yield less than expected program benefits.

*Victoria Police mental health and wellbeing services*

- There are no major capability gaps in current Victoria Police internal health and support services; but these services are under-resourced to the extent of current significant compromises occurring in service delivery adequacy that must be addressed.
- Victoria Police is already trialling innovative early intervention programs (e.g., the Trauma Group Pilot Program) and funding important research in suicide prevention and fostering healthy workplaces.
- There is a need for medical and psychology services to be better integrated; and change the fitness for duty assessment ('direction to attend') process: increasing earlier referrals (mainly via the impact of the organisation-wide mental health literacy program and leadership uplift), and having psychological fitness assessments undertaken by specialist trained psychologists.
- There is also a need to further build in-house mental health specialist capability (i.e., creating positions for a psychiatrist and clinical psychologist).

*Employee lifecycle health management*

- Victoria Police should progress towards implementing a more comprehensive employee lifecycle health management approach. This includes, integrating resilience training, physical health and mental health education content as 'foundational', that is, to be positioned on the same level as operational skills training – and accordingly, should become examinable.
- Family engagement in recruit training and subsequently across the employee lifecycle, needs to be upgraded and families made aware of ongoing avenues for seeking early support.

## Report Overview

- There was strong support from multiple internal and external stakeholders to implement regular wellbeing reviews across all employees.

  The Mental Health Review Team concluded that an overall mental health monitoring regime in Victoria Police must be aligned with the organisational mental health risk profile. Further, that this must be coordinated with the current safe-t-net system implementation.

  A wellbeing monitoring regime consists of: (a) formal wellbeing checks (mental health screening conducted by a psychologist); (b) an informal wellbeing check (welfare conversation conducted by a manager); (c) online self-managed wellbeing assessment; and (d) informal collegial wellbeing check with a co-worker.

  The Review Team concluded that investing in coordinating this wellbeing monitoring regime with safe-t-net (which will afford the means for better targeting wellbeing checks), and implementing the organisation-wide mandatory mental health literacy and leadership uplift programs - *will have more impact on improving mental health outcomes and reducing suicide risk than investing in any annual all-employee mental health screening process*.

- The Review Team further concluded that the safe-t-net system is at risk because Victoria Police has under-estimated the demands on people-leadership capability requirements that are needed to make the system work effectively. There is high variability in such skills at middle level manager roles (i.e., Sergeant, Senior Sergeant and Inspector). Hence, the critical importance of implementing VEOHRC and Mental Health Review Team recommendations around leadership capability 'uplift'.
- The Review Team concluded that Victoria Police suicide rates potentially can be significantly reduced (irrespective of the actual primary causes). This can be expected to occur in response to: (a) the implementation of the recommended comprehensive organisation-wide mental health literacy program; and (b) implementing leadership development initiatives that will increase organisational people-focused leadership capability. These initiatives will assist in increasing early recognition of mental health issues and validating early help seeking behaviour.
- The workers' compensation process can be challenging but some claims have an overlay of an industrial agenda that complicate how the system operates.
- An under-recognised key factor influencing return to work outcomes is perceived levels of workplace support, particularly from the immediate manager. This type of support is currently highly variable across Victoria Police. The Review Team anticipates that this can be effectively addressed via the recommended mental health literacy and leadership development initiatives, and increased accountability at local levels in relation to return to work outcomes.

- The clinical treatment received by many members suffering from significant mental health issues (including PTSD) is often not consistent with recognised best clinical practice. Moreover, biases have been identified among health professionals towards over-diagnosing PTSD and total work incapacity, by virtue of being a police officer or an emergency services worker.

  Hence, there is need to establish a state-wide specialist mental health network of Psychiatrists and Clinical Psychologists experienced in the treatment of PTSD with emergency services employees - who members can be referred to on an outpatient basis. Most individuals with genuine PTSD symptoms can be effectively treated on an outpatient basis. Moreover, the small number of members who may be 'gaming the system' could be expected to be reasonably managed via referrals to the specialist network, where appropriate clinically rigorous assessments can be conducted.
- There are genuine mental health issues experienced by many retired members that are related to their employment with Victoria Police. The recently established retired peer support program needs to be supported and appropriately funded.
- Further, all retiring members should undertake an exit interview and mental health screening assessment, and with any indicated health management plan, reasonable costs for work-related conditions should be funded by Victoria Police.

# Summary of Recommendations

**Recommendation 1:** That Victoria Police undertakes a prevalence study to gain accurate data on the organisational mental health and suicide risk profile. It is further suggested that other jurisdictions may be interested and hence the prospect for a national police services prevalence study be investigated. **(Chapter 3, page 21)**

**Recommendation 2:** That Victoria Police develops and implements an organisation-wide comprehensive mental health literacy program that involves mandatory participation for all employees and leaders. This program cannot be conducted under business as usual arrangements as there will be additional demands on content development, program delivery resourcing, expected increased demand on Police Psychology Unit services and overall major program coordination and implementation requirements. **(Chapter 4, page 33)**

**Recommendation 3:** To help kick start the organisation-wide mental health literacy program, a series of brief video vignettes should be developed, along the lines of the powerful police remembrance video, and include senior leaders, openly discussing their personal struggle with the impact of stressful operational incidents and other policing challenges. **(Chapter 4, page 32)**

**Recommendation 4:** Existing Police Psychology Unit workshop program content can be utilised but will need to be significantly refreshed and updated according to the mental health literacy principles detailed in the body of this report, and co-ordinated with other (e.g., online) delivery modalities and the overall comprehensive mental health literacy program. **(Chapter 4, page 33)**

**Recommendation 5:** The Review Team recommends that the design and development of a 'pulse survey' be progressed, specifically to assess progress with VEOHRC recommendation implementation and reduction in mental health stigma (particularly recognition of mental health issues in the workplace, willingness to report mental health issues and willingness to seek help). **(Chapter 4, page 33)**

**Recommendation 6:** The 'leadership uplift' program should commence with a series of Executive Command workshop sessions led by an expert people leadership consultant, and include mental health literacy content, directed towards achieving senior leadership team buy-in and alignment around the Mental Health Strategy (which will be developed on the basis of this report). The program should also include wellbeing/mental fitness being re-positioned as foundational (on the same level as operational training skills) and increased accountability and expectations for role modelling the indicated changes, values and expected behaviours. **(Chapter 5, page 35)**

**Recommendation 7:** Bring together related people functions into one executive portfolio to achieve the integration and co-ordination of functions that is required to achieve the needed culture change. **(Chapter 5, page 45)**

**Recommendation 8:** Reorganise and update all leadership programs around an overarching people oriented leadership framework, ensuring consistency of messaging across programs. Mental health literacy content should also be embedded and examinable as a mandatory component in all leadership development programs, especially sergeant and senior sergeant levels, as well as training in undertaking supportive conversations. Attendance at a minimum number of such programs (e.g., at least one per year) could be included in Professional and Development Assessments for accountability purposes. **(Chapter 5, page 40)**

**Recommendation 9:** Introduce appropriate weightings in the performance appraisal system to increase a focus on expected behaviours, and active management of inappropriate behaviours, in addition to standard Key Performance Indicators. **(Chapter 5, page 43)**

**Recommendation 10:** Revamp and relaunch Victoria Police Values and Expected Behaviours. It is recommended that 'Safety' be included as an additional value. **(Chapter 5, page 42)**

**Recommendation 11:** Consider an organisational climate survey for the next iteration of the VicPol culture change program to assist in driving increased people-related accountabilities. In the interim, a 'pulse survey' (as noted in Chapter 4) should assist. **(Chapter 5, page 44)**

**Recommendation 12:** Increase Police Psychology Unit Full Time Equivalent (FTE) positions. This needs to take into account additional service demands such as increased mental health screenings, provision of professional supervision services, increased coaching and leader support initiatives, workshop content updates and mental health literacy program delivery requirements. It is estimated that the Police Psychology Unit FTE increase will need to be 11 FTE positions. **(Chapter 6, page 51)**

**Recommendation 13:** Implement an integrated electronic client management system to enhance health and mental health service delivery and reduce the risk of not responding appropriately to client service needs. **(Chapter 6, page 50)**

**Recommendation 14:** Amend the Victoria Police Act to include specialist trained psychologists to meet the demand for psychological fitness for duty assessments. **(Chapter 6, page 52)**

**Recommendation 15:** Medical Advisory Unit and Police Psychology Unit should be co-located under the same Division of the Human Resource Department. **(Chapter 6, page 52)**

**Recommendation 16:** Establish a sessional Psychiatrist position and a 0.5 Full Time Equivalent Clinical Psychology position to build in-house mental health specialist assessment and advisory capability. The placement of these positions should be considered when determining the service delivery model as part of the VicPol Mental Health Strategy. **(Chapter 6, page 53)**

**Recommendation 17:** An appropriate and minimal level of professional and peer supervision is essential (and should be quarantined from funding cuts) to maintain service quality and protect internal health service providers against the psychological safety risk of vicarious trauma. The Police Psychology Unit can provide indicated supervision to Welfare and Peer Support Officers. **(Chapter 6, page 51)**

**Recommendation 18:** VicPol and The Police Association should renew efforts to work collaboratively on progressing a mental health and wellbeing agenda. **(Chapter 6, page 55)**

**Recommendation 19:** Resilience content in recruit training should be refreshed and updated, and mental health literacy and physical health education content be added. This content should be positioned as 'foundational' on the same level as operational skills training and thus should also be examinable. **(Chapter 7, page 57)**

**Recommendation 20:** Families should be invited to attend some mental health literacy and physical health education sessions during recruit training. Further, additional family engagement initiatives should be further investigated for implementation within Victoria Police**. (Chapter 7, page 59)**

**Recommendation 21:** The indicated organisation-wide wellbeing monitoring regime needs to be adequately resourced, above and beyond business as usual (i.e., increased Police Psychology Unit positions as detailed elsewhere). **(Chapter 7, page 61)**

**Recommendation 22:** The early intervention Trauma Group Pilot Program should be significantly expanded and adequately resourced. **(Chapter 7, page 63)**

## Summary of Recommendations

**Recommendation 23:** VicPol suicide prevention initiatives, as part of the organisation-wide mental health literacy program, should be aligned with the principles of the national suicide prevention framework and be consistent with forthcoming Victorian government suicide prevention initiatives. Further, reporting on suicide in all VicPol communications should be aligned with the Australian Government Mindframe guidelines. **(Chapter 7, page 64)**

**Recommendation 24:** Initial contact with injured employees should be refocused around a primary ongoing single point of contact and the development of a case management plan, developed by an Injury Management Consultant/Welfare Officer, with support for mental health issues as indicated, provided by the Police Psychology Unit. This will involve the creation of an additional six Welfare Services Full Time Equivalent positions. **(Chapter 7, page 66)**

**Recommendation 25:** Sessional specialist mental health input should be accessed, as indicated, to advise Victoria Police and the insurer as part of the claims determination process. This should be sourced externally, to keep Police Psychology Unit removed from any possible perception of conflict of interest/ supporting the insurer. **(Chapter 7, page 69)**

**Recommendation 26:** There is a need to review accountability for return to work programs. Appropriate accountability for return to work outcomes, at the local level, should be introduced. **(Chapter 7, page 67)**

**Recommendation 27:** The Review Team recommends that Regional and Departmental managers are assisted by the Human Resource Department in improving the process where locally established 'temporary' placements are used, where needed, as a standard staffing option. (N.B., Existing staff funding models may need to be reviewed as part of a broader expansion of flexible employment options under this review and also the VEOHRC Report). **(Chapter 7, page 69)**

**Recommendation 28:** Additional options for redeployment with other organisations should be further explored. **(Chapter 7, page 70)**

**Recommendation 29:** An external network of specialist mental health service providers (mainly psychiatrists and clinical psychologists) should be established, with service level agreements involving up front commitment to align their clinical practice with: (a) the Guidelines on the Treatment of PTSD in Emergency Services Workers; (b) the Australian Health Benefits of Work Agenda; and (c) the Clinical Framework. **(Chapter 7, page 71)**

**Recommendation 30:** As triaged by the Police Psychology Unit, in collaboration with the Medical Advisory Unit, some members in rural and remote locations where there is a lack of available appropriately qualified local mental health service providers, should be offered e-treatment access to a specialist mental health service provider, such as is now available via secure video conferencing facilities (accessed via web browsers). **(Chapter 7, page 73)**

**Recommendation 31**: All retiring Victoria Police employees should undertake a formal mental health screening, and where significant work-related mental health issues are identified, then a treatment plan should be devised and funded by Victoria Police. **(Chapter 7, page 74)**

**Recommendation 32:** The Retired Peer Support Network should be expanded and sufficiently funded to maintain an adequate infrastructure to manage referrals and monitor service quality. Along the lines of how the Department of Veterans Affairs operates, some function should also be established to manage funding and clinical quality assurance of indicated treatments for work-related conditions. **(Chapter 7, page 74)**

**Recommendation 33:** Sexual Offences and Child Abuse Investigation Teams should be allocated dedicated Police Psychology Unit support (Full Time Equivalent to be determined through further evaluation) to provide mental health screening as indicated, advice and coaching to management as required, training delivery, support for implementing supervision practices, and input into further Sexual Offences and Child Abuse Team prevention and risk mitigation initiatives. **(Chapter 8, page 77)**

**Recommendation 34:** A Sexual Offences and Child Abuse Investigation Team 'opt out' type provision, on either a temporary or permanent basis should be recognised, as may be identified via ongoing wellbeing monitoring (i.e., formal and informal wellbeing checks) and self-reporting. A maximum time in position policy is not indicated.
**(Chapter 8, page 76)**

**Recommendation 35:** It is recommended that a supervision model be introduced for Sexual Offences and Child Abuse Investigation Teams, as the Review Team is of the opinion that this would contribute towards substantial psychological risk mitigation. The Review Team makes no more specific recommendation as to the type of providers and frequency of sessions, as this should be determined via the outcomes of current Sexual Offences and Child Abuse Team projects and consultation.
**(Chapter 8, page 77)**

**Recommendation 36:** Appropriate consultation with Wellbeing Services should be undertaken by those VicPol internal and external agencies/bodies implementing disciplinary investigations, to ensure member wellbeing is appropriately taken into account. **(Chapter 8, page 79)**

**Recommendation 37:** It is recommended that the outcomes of the Critical Incident Response Team review in relation to the wellbeing management of VicPol members who are also Australian Defence Force Reservists, be considered as a basis for developing an organisation-wide policy and process for managing any potential mental health impacts of secondary employment.
**(Chapter 8, page 80)**

**Recommendation 38:** As part of the VicPol Mental Health Strategy, further consultation should be undertaken in conjunction with the Police Registration and Services Board, to develop appropriate career break options, including:

- Planned (and unplanned) career breaks;
- Expansion of the leave without pay policy;
- Review staff funding and counting model; and
- Consider the existing process around suspension of police powers (VP Act s.54) for extended periods of absence. **(Chapter 8, page 81)**

**Recommendation 39:** Honours and Awards undertakes a review of relevant criteria and processes, in conjunction with the Police Psychology Unit, to ensure that they are updated and consistent with the recommendations of this review.
**(Chapter 8, page 82)**

# Chapter 1: Introduction

Policing in Victoria has reached a tipping point: in endeavouring to sustain the Victoria Police core mission of fostering a 'safer Victoria', there are now too many employee casualties occurring along the way. With continually evolving community expectations, the ongoing need to address emergent forms of criminal behaviour (e.g., cross jurisdictional activities and internet-related crime), increasing reporting of sexual abuse and the focus on family violence; growing online child exploitation; and shifts from traditional forms of policing towards more victim-centric forms of policing - there are ever increasing demands on limited resources and organisational adaptability.

> *"Victoria Police will need to do more to enhance public safety with fewer resources." (Forward, Victoria Police Blue Paper, 2014)*

The question arises, 'At what cost'? How can Victoria Police achieve this? The interactions between work demands, ongoing resource constraints and work roles that also involve much higher levels of recurrent exposure to potentially traumatic events compared with any other industry sector - are associated with increasing occupational health and safety risks.

> *"I still love the job – but this is not a safe place anymore." (Detective Sergeant)*

At an organisation-wide level, there is always a tension between wellbeing and performance imperatives. The wellbeing side of the equation, in Victoria Police, appears to be increasingly compromised.

Most Victoria Police employees are required to attend events that the majority of the population never sees. They are frequently exposed to potentially traumatic events that may result in varying degrees of psychological distress responses.

This occurs repeatedly over the course of their working lives, and can be associated with increased vulnerability to the cumulative effects of such incidents both during their career and post career.

Additionally, as will be discussed in the body of this report, internal factors (e.g., workplace leadership and station/team climate) as well as personal factors (e.g., relationship breakdown and family problems) are also significant contributing factors.

Further, many respondents commented that workload pressures, and a perceived lack of government support for funding, also significantly contribute to employee mental health.

It is beyond the scope of the VicPol Mental Health Review to comment on Victorian government priorities and the political dimension of Government Agency funding arrangements.

We can only detail our findings based on more than 450 contacts with individuals and groups, involving interviews and written submissions; conducting an evidence-based research literature review; conducting an 'international environmental scan'; as well as consulting key external stakeholders including other jurisdictions, Phoenix, beyondblue, WorkSafe, expert mental health researchers, Unions and the Australian Defence Force.

Since the Mental Health Review commenced (in November 2015), there have been three sworn member suicide-related deaths. Since 2000, 23 employees (19 Police and Protective Services Officers and four Victoria Public Service employees) have died by suicide, whereas five officers have been killed in the line of duty.

Over the past 12 months, there have been escalating demands on available Victoria Police mental health and wellbeing related services. This, together with the harrowing impact of suicides on families of employees and colleagues, has prompted the initiation of this Review.

Another factor leading to the initiation of this Review has been the release of the Victorian Equal Opportunity and Human Rights Commission (VEOHRC) Report[1] that examined the extent and profile of gender discrimination and sexual harassment across the organisation.

This report has been very confronting for Victoria Police. It exposed an "entrenched culture of 'everyday sexism'"; "high tolerance for sexual harassment"; significant "predatory behaviour", and bullying. It also identified many individuals who have been significantly psychologically harmed during the course of their employment as a result of this culture and associated behaviours.

The VEOHRC Report anticipated the VicPol Mental Health Review project through:

- noting potential overlap in considering the mental health impacts and increased suicide risk experienced by many victims of gender-based discrimination and harassment; and
- formulating recommended improvement initiatives that would likely resonate with the VicPol Mental Health Review findings, i.e., supporting the need to urgently increase 'people-focused' leadership capability, local accountability around workplace behaviours, and fostering more supportive people-oriented work environments.

In the words of a leading industrial relations lawyer, from the recent beyondblue National Conference on the Mental Health of First Responders (March 2016):

> *"Why would employees comply with their duties in OHS law to disclose issues in accordance with their obligation to take reasonable care to prevent injury to themselves or others when they fear that such disclosure will be used against their ongoing employment? Unless, and until, management can inspire trust in the disclosure of health-related issues and commit to the wellbeing of their employees, employees will not disclose – and the organisation will forgo the benefits of trust-related discretionary work performance and commitment to their stakeholders, have no visibility of health-related risk and suffer high workers' compensation premium costs and absenteeism." (Andrew Douglas, Principal, Workplace Relations, Practice Group Head, Victoria, Macpherson Kelly)*

It is abundantly clear that the cultural drivers of gender-based discrimination and harassment significantly overlap with the drivers of mental health-related stigma and tolerance margins for bad behaviours that so strongly impede appropriate early help-seeking behaviours in relation to mental health issues. All of this points toward a need for significant culture change.

The Review Team notes that the overriding instruction from Chief Commissioner Graham Ashton was to fully determine the current state-of-affairs in relation to the mental health and wellbeing status of Victoria Police employees, and to provide frank and fearless advice on how mental health, wellbeing and suicide prevention outcomes for all sworn and Victorian Public Service employees could be improved.

1 VEOHRC (December 2015)

# Chapter 1: Introduction

The Terms of Reference for the Victoria Police Mental Health Review were as follows:

*The Victoria Police Mental Health Review will critically examine and report on how the organisation can best deliver wellbeing services to support employees throughout their career and into their post Victoria Police lives.*

*The Victoria Police Mental Health Review will:*

(1) *Report on international best practice on the provision of wellbeing services particularly as they relate to emergency services and defence forces;*

(2) *Review the efficacy and appropriateness of mental health and wellbeing services currently being delivered across Victoria Police and how they benchmark against best practice;*

(3) *Identify any service gaps or risks as well as alternative approaches; and*

(4) *Identify opportunities for improved services, interventions, information capture and how the services are best integrated.*

The VicPol Mental Health Review is proposed to underpin the development of a comprehensive Mental Health and Wellbeing Strategy for Victoria Police.

Note that throughout this report quotes from interviewees are used to illustrate the lived experience of current and former Victoria Police employees. These quotes have been carefully chosen to reflect multiple reported experiences.

*"I don't think it was only work that contributed to his breakdown. He had a messy personal situation and was at loggerheads with his Sergeant."*

# Chapter 2: Methodology

The Mental Health Review Team was established in November 2015, and has worked in conjunction with the Victoria Police Human Resource Department. There was agreement established that the consultation process should include a wide range of both mental health experts and other external, and all internal, stakeholders.

In order to obtain input, advertisements were placed in Victoria Police internal communications as well as externally in the general print media including newspapers, and television news stories. Other avenues publicising the Review included radio interviews.

The response has been significant. The Mental Health Review Team met with, or conducted telephone-based structured interviews, and reviewed written submissions, from over 450 individuals and groups including:

- sworn and Victorian Public Service (VPS) employees across all ranks/levels and Regions, Departments and Commands;
- retired sworn and VPS employees;
- family members of Victoria Police employees (serving, retired or deceased);
- other health professionals; and
- key internal and external stakeholders and subject matter experts.

Most of those who responded provided written submissions, whilst others chose to request an interview. Of those who responded, the vast majority were able to be contacted and interviewed either in person or by telephone.

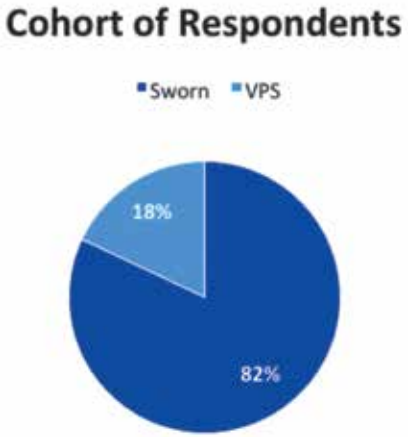
All interviewees were assured of confidentiality. The Review Team also conducted an environmental scan and a brief literature review.

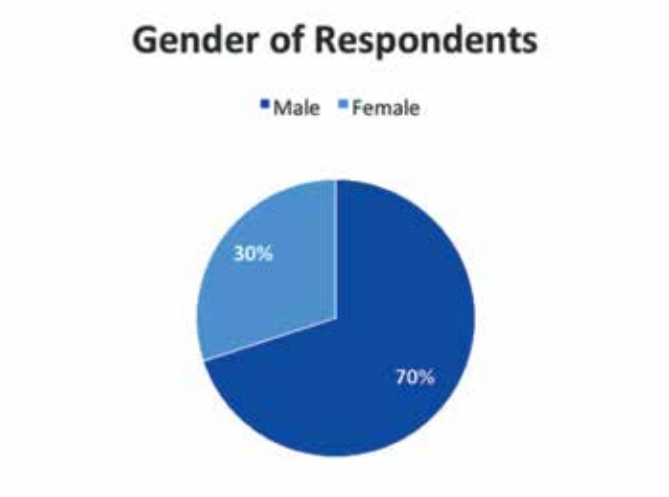
## Composition of sample

The Review Team consulted extensively within Victoria Police, speaking to sworn and VPS employees from across the organisation (including police, Protective Service Officers, Forensic Officers and Executive Officers).

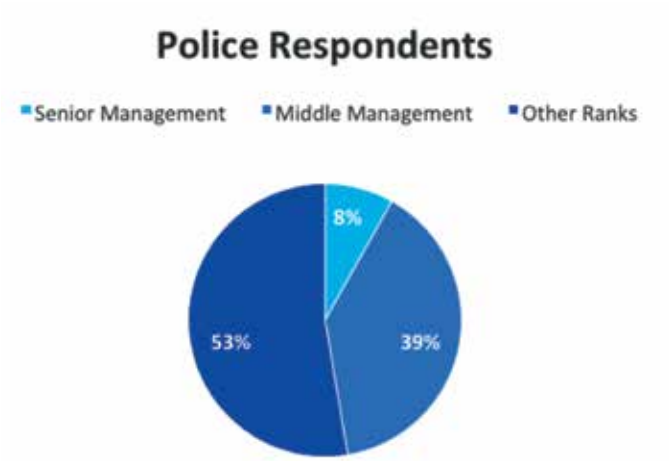
The Review Team conducted over 30 interviews with Commissioned Officers (Inspector to Assistant Commissioner ranks). The interviewed Commissioned Officers represent a broad cross-section of the organisation, including both operational and corporate environments. Around 50 percent of those interviewed were from Regional Operations.

Over 300 voluntary submissions were received from current employees. 82 percent of voluntary submissions were from sworn (police and Protective Service Officer) employees and 18 percent from VPS employees. 70 percent of respondents were male and 30 percent were female.

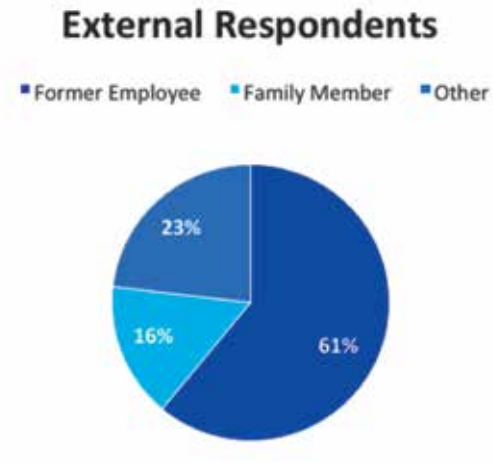





Of the police respondents, over 50 percent of submissions were from the 'Other Ranks', being Constable, Senior Constable and Leading Senior Constable. 39 percent of police respondents were middle managers, being Sergeants and Senior Sergeants.




In addition to the submissions received from current employees, around 100 voluntary submissions were received from people outside of Victoria Police. 61 percent of these were from former employees and 16 percent were from family members of employees. The majority of submissions received from former employees were from former police officers; many of whom had retired due to ill-health.




## Structured Interview Protocol

The structured interview protocol used by the Review Team included questions around:

a. Respondent observations about how mental health issues are currently managed in Victoria Police;
b. What has (or has not) changed since they started with VicPol in relation to the management of mental health issues;
c. Any suggestions for improving the management of mental health and wellbeing of employees;
d. Perception of available internal support services and any experiences with them;
e. What has helped them personally cope with any significant operational incident exposures and other stressors; and
f. Participation in any mental health and wellbeing related training.

The interview protocol also included some standardised statements on the current VicPol management of mental health and wellbeing issues; attitudes toward mental health issues and working with someone who has previously been diagnosed with PTSD or depression; personal willingness/ reluctance to seek help if you ever experienced any difficulties; and what type of help you would access. These questions were rated on a five point Likert scale (from Strongly Agree through to Strongly Disagree) and compared with a generic Australian workplace benchmark database.

# Chapter 3: Mental Health and Suicide Risk Profile and Contributing Factors

***Key findings:***

- *Posttraumatic Stress Disorder is not the only mental health risk: anxiety disorders, depression and substance misuse are just as, if not more, prevalent.*
- *Suicide risk is difficult to accurately appraise but is thought to be relatively higher in police and emergency service organisations compared with the general population.*
- *'Cognitive decline' (i.e., deterioration in concentration, memory functions and decision-making capability) is another emergent general working population mental health-related challenge.*
- *Key contributing factors to police mental health and suicide risk encompass more than exposure to potentially traumatic incidents. Work factors (including leadership style, management practices, workload pressures and overall 'station/team climate') as well as personal relationship difficulties are also significant contributors.*
- *This is also the case with exposure, e.g., to child exploitation materials and victims of child abuse: any 'vicarious trauma' related symptoms are greatly accentuated by unsupportive leadership behaviours and workload and resourcing pressures.*

*"The bucket fills up with so many things – who knows when it's going to tip?" (Detective Leading Senior Constable)*

The mental health issue that is most recognised across Victoria Police is Post-traumatic Stress Disorder (PTSD). However, we know that other mental health issues are likely to be just as, if not more prevalent including clinical depression (e.g., Major Depressive Disorder) and Substance Misuse (mainly alcohol abuse), as well as other sub-clinical issues such as anger control problems and other anxiety symptoms.

Available Police Psychology Unit data indicates that, over the past 12 months, the most common presenting issues for employees seeking help were: personal relationship problems, work trauma, other mental health issues (e.g., depression, other anxiety disorders), anger, alcohol abuse and workplace conflict. This profile is also consistent with the limited available data reviewed from other internal services.

Workers compensation claims provide a further indication. Reported diagnoses, based on reviewing medical certificates, include PTSD, depression, adjustment disorder (i.e., situational linked anxiety and depression) and 'stress-related illness' (not further specified).

The available presenting issues data provides a general indication. But we know that many employees with mental health-related difficulties choose not to access available services or submit a compensation claim, and may access alternative and external avenues for help, or frequently, seek no help at all. Many interviewees reported attending their own GP and being referred for mental health treatment in their local community. Avoidance of help-seeking was found by the Review Team to be extensive across VicPol (see Chapters 5 and 6). In this sense, the available data is flawed and indicative only.

Similarly, the extent of suicide risk is not straightforward. We know there have been 23 completed suicides across Victoria Police since 2000 – as contrasted with five officers who have died in the line of duty over the same time period. There are indications that police and other emergency service suicide rates may be higher than the general community. Available comparisons with general population data (typically expressed by the Australian Bureau of Statistics in terms of the number of suicides per 100,000) indicate only a slightly higher rate for Victoria Police (e.g., in 2013, 11.9 compared with 10.9 per 100,000 general population).

However, arguably this understates the police rate because police services have a front-end filter: pre-employment psychological testing screens out a significant number of vulnerable individuals. This has been referred to as the 'healthy worker effect'. Hence, this type of comparison may lead to under-estimating the actual rate.

Moreover, available figures do not include rates for retired police suicides. The Review Team learned that Coroners do tend to record "ex" or "retired" police officer in their database if the occupation is known – but, as far as the Review Team is aware, there has not yet been any review of the Coronial database and we were unable to look further into this given our reporting timeframe.

The Review Team noted that a recent Senate report on veteran mental health and suicide included evidence from Veterans Line (a telephone counselling service for veterans) that reported that the number of veterans identified at significant risk of suicide or self-harm has doubled each year since 2011-2012 (Senate report, March 2016).

Overall then, the police rate is likely to be significantly higher than the general population. Indeed, a recent systematic review and meta-analysis by Witt and colleagues (from Deakin University, and currently submitted for publication) found that "rates of suicide in protective and emergency services workers are significantly higher than corresponding rates in members of the general working population".

And what of current levels of active suicidal ideation?[2] This is unknown. Occasionally, at-risk individuals will get on the radar of police medical and psychological services, but in the majority of completed suicides, there has not been any prior contact, or any contact had occurred many years earlier.

The Review Team noted that the Police Psychology Unit has recently commenced a risk register of individuals with active suicidal ideation or with significant risk factors. Numbers on the register vary between eight and 24 at any given time. This, however, only reflects those members that are known to internal services.

Overall, there is no rigorous Victoria Police mental health disorder and suicide risk prevalence data available (i.e., accurate and granular data delineating the organisational mental health and suicide risk profile).

Accordingly, the Review Team concluded that a 'prevalence study' (e.g., similar to that conducted by the Centre for Traumatic Stress Studies at the University of Adelaide[3] for the Australian Defence Force), would be valuable and enable establishment of a baseline profile to clarify the precise extent of mental health and suicide risk. Such a prevalence study could also be used to fine-tune future mental health and wellbeing initiatives, resource targeting, as well as enable appropriate evaluation of the effectiveness of the mental health strategy. The Defence prevalence study referred to here has been used by the Australian Defence Force (ADF) in evaluating the impact of various initiatives.

The Review Team also noted that there may be some interest from other jurisdictions in a prevalence study and hence recommends that Victoria Police explore the prospect of a national police prevalence study.

In the interim, the Review Team found that there is sufficient evidence to conclude that the proposed Victoria Police Mental Health Strategy will need to take into account the full range of potential mental health issues indicated above, and not exclusively focus on PTSD.

2 Active suicidal ideation is distinguished from passive suicidal ideation. The latter involves transient thoughts of self-harm without specific plans or actual preparatory behaviours that have progressed in any way towards realising these thoughts. By contrast, active suicidal ideation involves some progress towards realising these thoughts through planning and some preparatory behaviours.

3 McFarlane, A. C., Hodson, S. E., Van Hooff, M., & Davies, C. (2011). Mental health in the Australian Defence Force: 2010 ADF Mental Health and Wellbeing Study: Full report. Canberra: Department of Defence.

# Chapter 3: Mental Health and Suicide Risk Profile and Contributing Factors

## 3.1 Contributing factors

*"I don't think it was only work that contributed to his breakdown. He had a messy personal situation and was at loggerheads with his Sergeant." (Inspector)*

There is evidence that emergency services, and police in particular, experience much higher levels of exposure to potentially traumatic events relative to employees in other industry sectors. There are cases of mental health problems arising directly from exposure to extreme events. There are other events that unexpectedly resonate with personal sensitivities (e.g., a deceased child exhibiting some physical characteristics similar to the member's child). When exposure is personalised in such a manner, the associated mental health risk is greater (Phoenix, 2013)[4] .

Further, it is clear that there can be a cumulative impact from operational experiences over time that increases the risk for the onset of mental health problems. The Review Team noted many harrowing accounts from long retired members (e.g., 10 years+ out of Victoria Police) who are evidently still genuinely struggling with life inhibitions, restrictions and social reclusiveness secondary to mental health-related difficulties, that in many instances, appear to be linked with their employment.

It is important to note that, in addition to the risks associated with operational incident exposure levels, there are other contributing factors which traditionally receive much less attention, and must also be taken into account. The Review Team noted lessons learned from the first iteration of the ADF Mental Health Strategy (2011 to 2015), namely a significant number of mental health problems identified were not directly linked to deployments (Morton, 2016)[5] .

It should be further noted that most individuals who join police and other emergency services organisations tend to self-select into these occupations and hence a degree of operational incident exposure is not unexpected. Therefore, such exposure may not necessarily have the same psychological impact as it might for unsuspecting individuals outside of these occupations.

The key additional factors include:

a. Personal stressors (e.g., relationship breakdown and family-related problems); and

b. Organisational factors (particularly leadership behaviours, co-worker interactions, tolerance level for bad (counter-productive) behaviours and workload pressures. These factors are often referred to as station/work team climate or psychosocial work quality).

Interviewees and submissions reviewed consistently indicated that these additional factors are perceived to be more impactful than operational incidents per se...

*"Give me a dead body to look at over a poor manager to deal with anytime." (Leading Senior Constable)*

*"The fact that I had a gun held to my head was not the issue; it's the fact that I was called 'ridiculous' by a superior who has known me for 15 years." (Sergeant)*

*"It's the enemy within! Who's going to get you in the back? I'd still be working but for the way I was treated within". (Sergeant)*

*"I coped with the work we do and the sworn stuff re us being second class citizens, but it was our manager who didn't seem to know how to deal with people..." (VPS member)*

4 The Australian Guidelines for the Treatment of Acute Stress Disorder and Post-traumatic Stress Disorder, Phoenix Australia (2013).
5 Personal communication, Mr David Morton, Director General Mental Health Strategy, Australian Defence Force (December, 2015).

*"The elephant in the room is the workload. I compare it to laying drain pipe. I used to be asked to lay 20 metres per day, now it seems more like 100 metres."*
*(Leading Senior Constable)*

*"The latest is the Family Violence industry. The work is important but we cannot deal with the demands now and it's like a flood coming around the corner. We start with 10 jobs on the plate, get a domestic violence job and still have 10 jobs left at the end of the shift".*
*(Leading Senior Constable)*

*"The workload demand is unbelievable. That's what stresses me out. Any business would say we aren't taking on any more work until after Christmas, but we just pile it up. There has to be a balance. We will never have enough police, so start dropping off some of the jobs. The systems don't work and I have no idea who reads half the stuff we have to do." (Detective Leading Senior Constable)*

Additionally, personal background vulnerability is a third contributing factor that needs to be factored into the mix (e.g., psychological risk factors linked with family of origin and childhood trauma). This element is mostly minimised through pre-employment psychological testing undertaken during recruitment (at this time, with sworn and Police Custody Officer recruitment only). Psychological testing is demonstrably effective in detecting a significant number of individuals with risk profiles that render them unsuitable to undertake police work, but it is not infallible. Some vulnerability factors are quite dormant and subtle, and can be difficult to detect, only becoming an active contributing factor under very particular circumstances.

Moreover, all of the noted contributing factors can interact in complex ways. Against a backdrop of cumulative incident exposure, personal relationship problems can often be a proximate trigger for the onset of mental health problems and increased suicide risk.

Further, workplace problems (often referred to as a negative station/team climate and unsupportive leadership behaviours), significantly increase the risk for more adverse responses to operational incident exposure. By contrast, supportive leadership styles and a positive high quality station/team climate serve as protective factors, increasing employee morale and directly contributing to risk reduction, as well as cushioning the impact of vulnerability factors (Hart and Cotton, 2003)[6] .

The Review Team noted the emergent focus on initiatives around promoting positive mental health at work (e.g., SuperFriend, 2015; the Victorian Workplace Mental Wellbeing Collaboration, 2016)[7] . In an occupational health and safety sense, given that the risk of incident exposure in frontline policing can never be fully mitigated by virtue of the nature of the work involved, concertedly building workplace protective factors opens a further avenue that warrants increasing attention.

One formulation that illustrates the interactions between risk factors, and resonates with many of the trajectories described by interviewees that participated in the Review has been termed the 'erosive stress pathway' (Tuckey et al., 2012)[8] .

6 Hart PM & Cotton P (2003). Exploring Police stress in an organisational health framework. In Occupational Stress in the Service Professions (Eds.) M Dollard, A Winefield & H Winefield. Taylor and Francis: London.
7 Promoting positive mental health in the workplace, SuperFriend (2015); Victorian Workplace Mental Wellbeing Collaboration - WorkSafe, Vic Health & SuperFriend (2016)
8 Tuckey MR, Winwood PC & Dollard MF (2012). Psychosocial culture and pathways to psychological injury within policing. Police Practice and Research 13:3.

# Chapter 3: Mental Health and Suicide Risk Profile and Contributing Factors

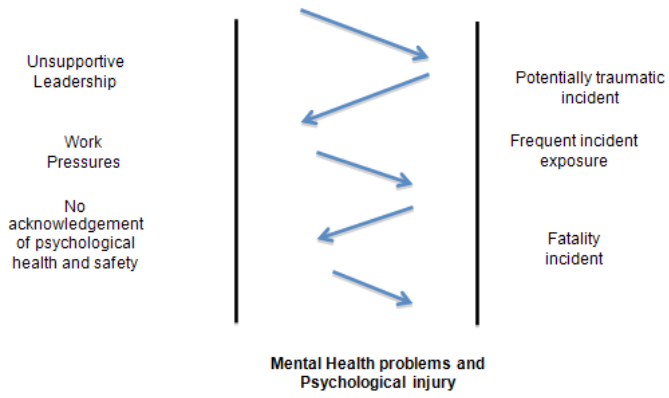



Figure 1: The erosive stress pathway

This figure depicts the downward spiral that can occur through the impact of negative organisational experiences influencing progressively more negative evaluations of operational experiences.

The Review Team also noted particular challenges reported by members working in rural and remote locations and single officer stations.

> *"I am the only police member living and working in XXX. So I get approached in the street off duty, in the shops, at the golf club, at social functions ... I get contacted on personal email, personal phone and social media. Try walking a day in my shoes and the shoes of my associates..." (Sergeant)*

Specifically in relation to suicide, the contributing factors are multiple. Whilst depression and other mental health problems are recognised significant contributing factors, there are some instances of completed suicides where the individual had no diagnosable mental health disorder. Moreover, work may not be a primary cause at all. As the relevant literature often notes, the causes of suicide are 'multi-factorial' and *it is not possible to predict in many instances*.

The literature makes reference to 'psychache' or psychological pain that at some point becomes intolerable for the individual (Schneidam, 1993)[9] . This can be frequently linked to a mental health disorder or may be more related to existential concerns, and is often not disclosed to anyone. Background vulnerability factors, personal and family stressors, experiences of perceived defeat/humiliation and entrapment, workplace experiences and access to means – all interact in complex ways (e.g., O'Connor, 2011)[10] .

Recent research commissioned by Victoria Police and undertaken by Deakin University (Witt K et al., 2016, in press) includes reference to relevant literature suggesting that approximately 17 percent of suicides, at a general work population level, can be attributed to work-related factors (Routley and Ozanne-Smith, Work related suicide in Victoria; Int J Injury Control and Safety Promotion, 2012; Vol. 19:2). But this is not police specific data. The current Deakin research (Systems Evaluation for the Prevention of Suicide, 2016) is specifically examining interactions between members and Victoria Police organisational systems to identify potential avenues for developing policy improvements and risk mitigation interventions. In the development of a suicide prevention strategy, specific attention will need to be given to organisational structures and processes and how they may contribute to suicide risk.

The Mental Health Review Team was also made aware of the impact of cognitive decline on individual members, their families and their co-workers. This was raised by a number of interviewees, and is more broadly recognised as an emergent general workplace occupational health issue. Early signs of cognitive decline include changes in behaviour, which can be manifested in the ability to perform familiar tasks, risky behaviour, problems with language, poor or decreased judgement, problems with abstract thinking, memory loss, misplacing things and changes in mood.

9 Suicide as psychache, Journal of Nervous and Mental Disease, 181, 147-149.
10 Towards an integrated motivational-volitional model of suicidal behaviour. RC O'Connor et al, International handbook of suicide prevention

Compensating behaviours such as withdrawal, an increase in drinking or other self-medication and defensive or aggressive reactions, which previously were not displayed, may also be in evidence.

Risk factors for cognitive decline include those for other major diseases such as diabetes, vascular disease, Parkinson's and heart disease and lifestyle factors including long term heavy alcohol consumption. Also linked to cognitive decline, can be head injuries and mental health conditions. With some 340,000 Australians currently living with dementia, there are now 1,700 new cases each week. While dementia is more common in people aged 65 and over, early signs may appear in individuals in their 40s and 50s.

For those in management positions, it will be important to be able to recognise the early warning signs, which could be confused with other mental health conditions, stress, performance management issues or an underlying physical condition - that will need to be ruled out.

Also important will be for managers/supervisors to understand the impact on someone's partner or parents who are experiencing cognitive decline. VicPol members in their 50s and 60s will be coping with elderly parents and will bear the expected burden of case managing an often lengthy process, that starts with the difficulties of diagnosing, becomes increasingly time consuming due to supporting parental choices and expectations, coordinating specialist care and inevitable accommodation and dealing with grief, guilt and loss.

## 3.2 The issue of vicarious trauma

Here we can also note the emergent issue of 'vicarious trauma'[11], which has particularly been identified as a potential risk for sworn and VPS employees working with victims of child abuse, their statements, and online child exploitation material.

Sexual Offence and Child Investigation Teams (SOCITs), for example, can invest in helping victims and can potentially experience frustration when a matter does not proceed to prosecution. In some instances, this may be cumulative and increase psychological vulnerability. SOCITs are regularly exposed to the emotional distress of victims and families, and interact with victims over an extended period of time.

All available indications, from interviews conducted with those investigating online child exploitation, as well as considering work undertaken by one of the Review Team members with other Commonwealth and State agencies working in this area - consistently suggests that any impact of exposure on levels of wellbeing is significantly mediated by other factors: particularly leadership style and management behaviour, as well as workload and resourcing issues.

> *"SOCIT work is so different. The service component is at another level. It's often not appreciated or understood and the management of SOCIT operatives is more harmful than the subject material." (SOCIT Operative)*

> *"Superintendents and Inspectors damage SOCITs more than any other. They belittle the crime method and take their resources." (SOCIT, Leading Senior Constable)*

> *"We needed to vary the hours – 10 to 14 hours a day watching vile pornography. We need help!" (Leading Senior Constable)*

11 As recently recognised in the diagnostic system used by most Australian mental health professionals (i.e., DSM-5, American Psychiatric Association). Note that the DSM cites as an example, "police officers repeatedly exposed to details of child abuse" (p. 271).

# Chapter 3: Mental Health and Suicide Risk Profile and Contributing Factors

The Review Team heard a number of harrowing accounts where officers were overwhelmed by the sheer volume of material dealt with, and viewing guidelines were evidently not followed due to excessive workload pressures.

The Review Team concluded that any impact of recurrent exposure to online materials or accounts of child abuse is significantly accentuated by unsupportive leadership behaviours and workload and resourcing pressures.

This suggests that protecting the mental health of employees working in these areas will require a broader focus, above and beyond image viewing guidelines, use of Net Clean and personal resilience building initiatives. Whilst initial work has reportedly commenced to scope a workplace initiative to address SOCIT workplaces and support systems, competing resources and priorities have delayed its formal commencement. These matters are further discussed in Chapter 8.

## Recommendation:

1. **That Victoria Police undertakes a prevalence study to gain accurate data on the organisational mental health and suicide risk profile. It is further suggested that other jurisdictions may be interested and hence the prospect for a national police services prevalence study be investigated.**

## What would progress look like?

**This project should be scoped and initiated within six months of the conclusion of the Review (i.e., by the end of October 2016).**

*"You can break a leg it's OK – break your mind and people run away. They don't want to know."*

# Chapter 4: Mental Health Stigma and Victoria Police Culture

***Key findings:***

- *Delayed help-seeking is a key issue that must be addressed in order to improve mental health and wellbeing, and reduce suicide risk across Victoria Police.*
- *Delayed help-seeking occurs due to a relatively low level of mental health literacy as well as fear of detrimental consequences for reputation and career prospects.*
- *Mental health stigma is entrenched and widespread across Victoria Police.*

*"I refused to believe it was a mental health issue because the common term for this sort of person is a 'nuffy'." (Detective Senior Constable)*

*"My very first job was the death of a child. My Sergeant moved the box of tissues away from me and told me that I needed to suck it up." (Sergeant)*

*"I went to my GP, who has known me for 15 years and was told I had 'Psychological Fatigue' and I could have a sickness certificate for a very extended period but I didn't want to do this because it would be a scarlet letter on your back." (VicPol member, 20 years)*

The Review Team consistently found that individuals with emergent mental health-related difficulties had tended to delay seeking help or avoided seeking help altogether. A VicPol member for 37 years and now retired related:

*"I probably suffered from stress for four to five years before I sought help. I thought I must have had cancer and was tested repeatedly, tried different medications, but nothing was working. One night I got into a state, locked the door, turned out the lights, refused to answer the phone and cried like a baby." (VicPol member, 37 years)*

Many interviewees spoke about not recognising early signs in themselves or, when they eventually did, delaying seeking help or deciding not to seek help at all.

To improve Victoria Police mental health and wellbeing outcomes, it is imperative to increase early help seeking behaviours. This must be the overriding priority for any mental health strategy. Delayed help seeking is associated with the development of more severe symptoms, longer duration of treatments and less prospect of returning to full operational duties.

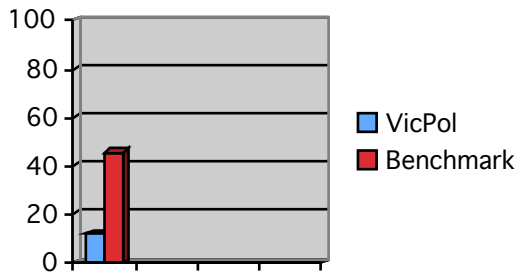
The Review Team concluded that there is a major barrier to timely and appropriate help seeking across Victoria Police, and that is mental health stigma. The Review Team concluded that mental health stigma is widespread and entrenched across Victoria Police.

*"If two people went for the same job and you've had stress leave, you won't be the person selected as they'll think this person is not as good or might fall over." (VicPol member, 28 years)*

The structured interview protocol used by Review Team members included a section with some basic mental health literacy questions (e.g., attitudes, awareness and myths about mental health issues) that were able to be quantitatively evaluated.

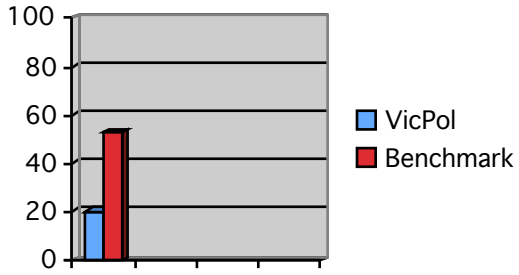
Table 1: Graphs summarising mental health literacy question results

These graphs summarise results for 235 respondents, sampled across Victoria Police.

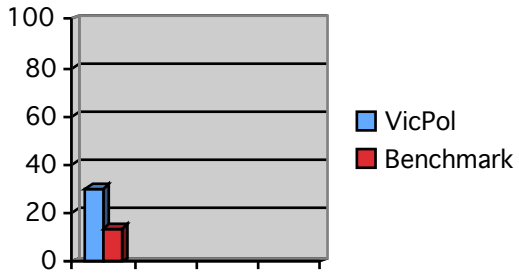



*Employer support:* Mental health issues are well managed in Victoria Police.

N.B. The benchmark reference is from a multi-industry sector data-base and is not emergency service specific. It compares VicPol scores with the average score across a wide range of Australian organisations.




*Willingness to report and seek help:* For any emotional problems I had following a critical incident, I would be willing to tell my manager and would seek any assistance from Vic Pol health services. The major reason cited (by those who endorsed Strongly Disagree or Disagree) was overwhelmingly: 'fear about impact on my career prospects'; and 'others would think less of me'.




*Attitudes towards mental health disorders:* Members who have been diagnosed with PTSD should be discharged from Victoria Police.

These results suggested that Victoria Police generally is characterised by poor perceptions of employer support for individuals experiencing mental health issues, marked reluctance to report mental health issues and seek help, and higher than average stigmatising attitudes towards mental health issues. These results are also consistent with the beyondblue National First Responder Organisation Audit (2015) that suggested relatively lower levels of mental health literacy in police services compared with other emergency service organisations.

## 4.1 Two levels of mental health stigma

The Review Team concluded that mental health stigma operates on two levels. Level One Stigma is about the recognition of signs of mental health problems, understanding of the causes and consequences of mental health disorders and appropriate attitudes (i.e., most mental health issues are treatable and most individuals do return to full functioning). Individuals tend not to recognise signs of mental health difficulties in themselves as early as would be optimal.

> *"My wife was going to leave me due to my erratic behaviour so after being pressured by my father, I sought counselling but the psychologist showed no interest and asked mundane questions about nothing, nothing of the incident, nothing about what I was feeling. It happened again and my wife was ready to go and my father intervened again and said I must call welfare and this time I saw*

# Chapter 4: Mental Health Stigma and Victoria Police Culture

*another psychologist and we began to work through the incident piece by piece." (VicPol member, 15 years)*

Colleagues and managers also tend to either not recognise these signs, or otherwise if and when they do, avoid responding.

When asked about the lack of response, colleagues and leaders typically responded to the Review Team by indicating: (a) not knowing what is appropriate to do; or (b) reported a fear of making the problem worse; or (c) indicated that it is not their role, and that the individual would be aware of available support services if they chose to seek help.

Level Two Stigma is about avoidance of help seeking when signs are recognised due to perceived detrimental consequences. Many individuals told the Review Team that they had delayed or avoided seeking help when problems were recognised, because they had a fear of being treated differently or of anticipating adverse consequences on their career prospects.

*"I will be viewed as damaged goods if they find out." (Leading Senior Constable)*

*"I had three big hurdles to overcome: (1) Admitting I needed help; (2) That medication was required; and (3) 'Coming out' – the stigma is so strong." (Retired Sergeant with PTSD)*

*"I was two weeks away from having my promotion confirmed and I didn't want to tell the Sergeant I was really struggling after attending a gruesome murder scene." (Leading Senior Constable)*

These fears are not without merit. The Review Team heard numerous anecdotes from multiple interviewees about the "suck it up" attitude that many leaders exhibit towards mental health issues.

*"Two officers were sitting and talking about the distressing suicide of a colleague two days earlier and providing some informal support to each other, when a Sergeant walked by, paused, and said to them, 'Do you want to be fucking social workers or police officers?'" (Leading Senior Constable)*

VicPol members often related the "suck it up" culture in anecdotes relating to their own early exposure to trauma:

*"We had a supportive work group and I went to the pub and got pissed - you didn't want to be one of the Nancy boys." (VicPol member, 38 years)*

One of the Review Team members coined the term 'the John Wayne syndrome' following review of many contrasting accounts by members physically or psychologically injured. If a member is shot or physically injured in the line of duty, he or she is immediately almost smothered with support from all directions – in some instances even receiving calls in hospital from politicians. However, if a member developed severe PTSD after attending a horrific incident, or, e.g., a series of fatalities in rapid succession, the response is much more ambivalent. In many instances described to the Review Team, the response was actively negative. The Review Team heard many stories of changes in how individuals were treated after their mental health diagnosis became known.

*"You can break a leg it's OK – break your mind and people run away. They don't want to know." (VicPol member, 16 years)*

*"After I had recovered from a serious depressive illness that also involved a suicide attempt, and returned to work, I found that my Sergeant – whom I had known well for more than 15 years and had been quite close to, started to avoid me and stopped speaking with me. As a result, I eventually had to move to another station." (VicPol member, 11 years)*

The paradox here is that *early help seeking increases the prospect of return to full operational duties*: delays in help-seeking diminish this prospect and increase the

likelihood of more protracted treatment, longer time off work and eventual return to a lower level of functioning. Early reporting is inhibited by current Victoria Police culture.

There are currently many Victoria Police employees who have fully recovered from significant mental health problems and who have returned to full functioning without restrictions. The litmus test for a 'mentally healthy workplace' is that if frontline employees are asked, they will state that they are confident that if they or a colleague developed a mental health problem, they would be well supported in the workplace. This is clearly not the case now across Victoria Police, other than some notable workgroup exceptions.

One further quite challenging factor that contributes to mental health stigma – and needs to be acknowledged – is that whilst the vast majority of individuals are genuine, there is a small cohort of hitherto well-functioning individuals who are diagnosed with PTSD by a GP or Psychologist, the day after a performance discussion with their manager or a meeting with Professional Standards. In other words, they use mental health language and medical certification as a deliberate avoidance strategy.

> *"There are some who game it and it's a shame because innocent people get burnt. They get advice about getting on a benefit saying 'do this, do that' and this is really sad..." (VicPol member, 22 years)*

The Review Team believes that this issue can be largely addressed through gaining better quality medical information and rigorous specialist mental health assessments (we discuss this in more detail in Chapters 6 and 7 and make specific recommendations).

Level One Stigma is most appropriately addressed through increasing organisational mental health literacy. This should involve the implementation of a comprehensive program of tailored educational initiatives, delivered through different modalities (e.g., face-to-face and online), across all levels of an organisation. Further, given the degree and size of the risk involved across Victoria Police, it should also involve a mandatory mental health literacy component embedded in all leadership programs, across all levels.

The VicPol Psychology Unit currently offers a suite of mental health literacy workshop programs, including *Healthy Minds @ Work Foundation Training* (focused on the individual and self-care); *Healthy Minds @ Work Manager Session* (focused on managers and involving a skills component in undertaking conversations with at-risk employees); and *Healthy Minds @ Work VPS Session* (similar content oriented towards VPS employees).

These programs are not mandatory and take up has been positive but very patchy across the organisation, with difficulties in accessibility and reach, and also resistance to participation in some areas. There has also been a significant lack of uptake of these programs by ranks above Inspector. This is likely to be reflective of the leadership cultural issues discussed in the next Chapter.

Victoria Police is also currently sponsoring an innovative pilot research program, being implemented by a Deakin University research team, Creating Healthy Workplaces. This program includes a substantive mental health literacy component as well as a leader coaching program that also aims to improve the local management of workplace health and safety risks (la Montagne et. al., 2016)[12]. The results of this study will not be available until sometime after completion of the current review. Initial results indicated that the high level of mobility of station leadership is negatively impacting on the intervention and remains a constant challenge for program engagement.

There is no mandated mental health literacy content in any Victoria Police leadership programs. Historically, there has been some mental health literacy content included in various programs, particularly at the front end (i.e., recruitment phase), but this frequently ends up being excluded from programs due to the priority accorded to operational training content.

12 http://www.biomedcentral.com/1471-244X/16/49

# Chapter 4: Mental Health Stigma and Victoria Police Culture

*"Managers need to be looking at every individual's mental health and addressing early warning systems - and we don't do that well." (VicPol member, 40 years)*

Mental health literacy programs aim to:

a. Increase recognition of early warning signs;

b. Provide accurate information about mental health issues including risk and recovery prospects, and suicide;

c. Detail the benefits of and encourage early help seeking behaviour;

d. Provide information about key evidence-based treatment options for common mental health conditions;

In relation to (d), it is recommended that some content from the recently released *Guidelines for Treating PTSD in Emergency Services Personnel* (2015) be included and the language tweaked to be suitable for all employees. As will be discussed in Chapter 7, individuals with significant traumatic stress symptoms frequently do not gain access to appropriate treatment. Hence, we recommend that employees, as potential health service consumers, are educated to understand the importance of gaining access to appropriate treatments - as delineated in these Guidelines.

e. Clarify appropriate ways to engage with and support a person in the workplace who may be experiencing mental health-related difficulties; and

f. Foster a sense of shared responsibility amongst employees 'for looking out for one another', or as has been described elsewhere, the 'Mates for Mates' type concept. There will be occasions when a colleague is the first to notice that another team member is struggling and should feel empowered to be able to approach them directly and encourage them to seek help.

It is standard nowadays in mental health literacy programs to tailor content for employees and for managers (as the current Police Psychology programs do).

The Review Team noted that Victoria Police is currently in the process of developing a new online platform (mental health portal, external website and mobile phone Application) that will include significant mental health literacy content (see Chapter 7 for further discussion). This platform, in the Review Team's view, should be an integral component in the proposed mental health literacy program.

The Review Team noted that in another sector, not generally known for its level of mental health literacy, namely the legal profession, that there has been a positive impact from vignettes featuring senior members of the legal profession disclosing their personal struggles with mental health issues (e.g., Resilience@Law and Wellbeing and the Law Foundation). The Review Team further noted the powerful Victoria Police Remembrance Day video – featuring senior officers commemorating members fallen in the line of duty.

Based on these considerations, the Review Team recommends that as part of the proposed overall Victoria Police Mental Health Strategy, a series of such vignettes, preferably including Command members be developed, to 'kick start' the organisation-wide mental health literacy program. A number of interviewees noted that sports figures, celebrities and politicians who have exposed their own struggles with mental health have helped normalise mental illness and have positively impacted on the public's awareness with what they live with or have experienced in the past. When queried whether this could be replicated for VicPol, most were supportive.

Similar vignettes have been used successfully in Victoria Police under the Zero Harm program over the past few years and are included in the safe-t-net online training program that will be commencing shortly. Police Psychology is also endeavouring to develop a 'library of sorts' of lived experience vignettes across the range of common workplace mental health issues.
It is reiterated that whilst it is very appropriate to develop such vignettes across a range of ranks and include sworn and VPS employees, the more that senior officers

are involved, the more positive organisation-wide mental health literacy impact there tends to be.

Overall, the Review Team recommends that Victoria Police implements a comprehensive mental health literacy program that includes *core mandatory components to be embedded in recruit training and all levels of leadership programs*. The program should coordinate face-to-face workshops with online content and include content tailored for both managers and employees. Some of the basic content for such a program has already been developed via internal resources, or is under development with the new online platform. The vignettes described above could be used as a 'kick start' to the comprehensive mental health literacy program.

It is critical to note that the recommended comprehensive organisation-wide mental health literacy program cannot be developed and initiated under business as usual arrangements: existing content needs significant refresh, there is additional content that needs to be developed; other resourcing in terms of trainers, and increased demand on internal support services; and careful strategic coordination of all components to effectively implement the program.

The Review Team also favourably noted the Australian Defence Force approach of linking resilience and mental health issues around the 'foundational strength' of 'mental fitness'.

There is a trend, in contemporary approaches to mental health literacy, to embed mental health educational content in a broader positive focus on promoting psychological wellbeing at work. This could be addressed in the recommended refresh and co-ordination of existing content to contribute to the comprehensive mental health literacy program proposed for Victoria Police.

We note that the Board of Ambulance Victoria has, in March 2016, signed off on a $1million investment in an organisation-wide mental health literacy program that involves multiple modalities and delivery formats.

## Recommendation:

2. **That Victoria Police develops and implements an organisation-wide comprehensive mental health literacy program that involves mandatory participation for all employees and leaders. This program cannot be conducted under business as usual arrangements as there will be additional demands on content development, program delivery resourcing, expected increased demand on Police Psychology Unit services and overall major program coordination and implementation requirements.**
3. **To help kick start the organisation-wide mental health literacy program, a series of brief video vignettes should be developed, along the lines of the powerful police remembrance video, and include senior leaders, openly discussing their personal struggle with the impact of stressful operational incidents and other policing challenges.**
4. **Existing Police Psychology Unit workshop program content can be utilised but will need to be significantly refreshed and updated according to the mental health literacy principles detailed in the body of this report, and co-ordinated with other (e.g., online) delivery modalities and the overall comprehensive mental health literacy program.**
5. **The Review Team recommends that the design and development of a 'pulse survey' be progressed, specifically to assess progress with VEOHRC recommendation implementation and reduction in mental health stigma (particularly recognition of mental health issues in the workplace, willingness to report mental health issues and willingness to seek help).**

## What would progress look like?

**Progress with the organisation-wide mental health literacy program could be assessed via indications from the pulse survey that may be periodically implemented on a representative sample basis.**

# Chapter 5: Why Victoria Police Leadership Culture Needs to Change

***Key findings:***

- *Leadership culture change is vital to improve mental health, wellbeing and suicide prevention outcomes. This is the only way to reduce the deeper layer of mental health stigma and increase early help seeking behaviour.*
- *The indicated leadership culture change requires more than a training solution.*
- *Leadership culture change is also needed to build key workplace protective factors that help buffer the impact of operational incident exposure.*
- *Leadership culture change is further required in order to realise the full potential of other proposed mental health and wellbeing initiatives.*
- *This is challenging, but as the Australian Defence Force has shown with its Pathways to Change program, significant progress can be made.*
- *The indicated leadership culture change involves increasing people-focused leadership capability that must primarily be demonstrated through leaders developing team-based structures and processes that foster support; open and honest communication and clarity of expectations; engage staff through involvement in day-to-day decision making; reflection on operational challenges and encouragement of feedback and debate; and build ownership and shared values. This type of team climate enhances employee morale and reduces mental health risk.*

The second level of mental health stigma is more challenging to address and reduce. The VEOHRC Report (2015) alludes to this challenge through its focus on addressing gender discrimination and sexual harassment. VEOHRC concluded that there is a need to increase 'people-focused leadership' capability across Victoria Police, and the Review Team supports this recommendation. However, the Review Team considers that this notion requires some further elaboration and clarification.

The Review Team concluded that people-focused leadership cannot be an end in itself. If that were to be the case, then there would be a risk of fostering warm work relationships and leader-centric teams that still do not substantively increase morale, engagement and reduction of mental health risk. People-focused leadership will not be effective unless it is directed towards putting in place the team-based structures and processes that engage staff effectively in open and honest communication about operational issues; build shared values, ownership and clarity of expectations, as well as accountability for results; foster expected behaviours; engage team members in day-to-day decision-making processes; and encourage feedback, debate and learning. This need for people-focussed leadership was commented on by sworn and VPS members including this VPS member:

> *"There are problems at the top level and the solution always seems to be to put in another level of management. This means there is a gulf between the two that gets worse."*
> *(VPS member, 28 years)*

It is through team-based processes, experienced on a day-to-day basis, that morale is increased and mental health risk reduced. Fostering this type of team environment also includes developing a 'climate for wellbeing' (i.e., a positive team environment where leader role modelling validates early help-seeking behaviour and 'support' becomes a shared function with team members also 'looking out for one and other').

In any industry sector, there are some leaders that achieve better employee engagement, productivity and wellbeing-related outcomes. This is largely attributable to higher levels of 'people-focused' leadership invested in building the type of team climates[13] described above – and is over and above sector specific technical competencies.

What is clear is that achieving substantive improvement in relation to Level Two Stigma requires more than a 'training solution'. It points to the need for leadership culture change. The Review Team further concluded that leadership culture change across Victoria Police is required in order to support the effectiveness of the organisation-wide mental health literacy initiative discussed in Chapter 4, and also improve suicide prevention outcomes (the latter is discussed further in Chapter 7).

## 5.1 Understanding the role and mental health impact of 'people-focused' leadership

To begin with, we note some lessons from the organisational psychology and organisational behaviour literature. These will help to frame our comments.

### *Excessive reliance on operational incident leadership style*

> *"VicPol needs to promote people with the right skills as some areas are ingrained with operational methodologies which are counterproductive." (VicPol member, 19 years)*

People working at any level in an organisation cannot be effectively led in exactly the same way as people in an operational incident situation. In the latter situation, directive leadership is indicated, but outside of this situation, excessively directive leadership causes disgruntlement and reduces morale and engagement. This leadership style has been linked to bullying complaints and psychological injury workers compensation claims across a number of industry sectors. A number of interviewees provided feedback along the lines of the quote below:

> *"Someone is behaving badly - like being late, angry or careless with record keeping. The response from the supervisor is to send a blanket email. This is not the way to go. You need to know your people and recognise what is happening and then confront it." (VicPol member, 18 years)*

As an example, in the Commonwealth sector, like most agencies, the Department of Defence experienced a significant upsurge in psychological injury compensation claims in the late 1990s. A significant contributor to this increase was linked with serving personnel returning to take up managerial positions in the civilian workforce. Some of these individuals tended to exhibit a highly black and white cognitive style and overly directive leadership behaviours. As a result, they left a trail of discernible human misery and psychological injury risk in their wake as they moved around the civilian workforce.

Police leadership culture is rooted in operational incident management experiences and hence the directive, chain of command approach has historically tended to carry over into non-operational incident workplace environment. This type of leadership style does not contribute to building morale and hence is another reason why building people-focused leadership capability should now be an organisational priority.

13 'Climate' is defined in terms of the day-to-day employee experience of the impact of policies, practices and procedures, as well as observations around behaviours that are supported or discouraged by leaders in their local work environment. There is an overall organisational climate and then sub-climates (i.e., distinct team-based climates within the overall climate; as well as climates for service delivery, wellbeing, innovation etc. in any organisation). See B Schneider et. al., Organisational Climate and Culture, Annual Review of Psychology, Vol 64. (2013). Climate is the 'face of culture': culture is about the deeper norms governing 'how we do things around here'. Culture cannot be measured directly, whereas climate can. It is through changing climate that culture shifts. Hence the focus for achieving genuine organisational change needs to be around demonstrated changes in leadership behaviours and team management practices that are manifested in the day-to-day team operating environment.

# Chapter 5: Why Victoria Police Leadership Culture Needs to Change

The issue of the role of directive leadership style can be further understood in terms of differentiating between the 'What' and the 'How'. The critical incident/ operational directive style is mostly focused on the 'What', but the key differentiating factor is the 'How'. In other words, it is how leaders take control of a critical incident and how they communicate with team members in managing these situations. It also depends on the level of trust and respect (which optimally must be two way) that is present during the management of these incidents – and this, in turn, depends on the leadership style exhibited on other occasions outside of any operational incident (e.g., in the day-to-day team environment). *Hence, people-focused leadership and the associated positive and engaging team environments, also directly contribute to enhancing the management of operational incidents.*

### *Core business and OHS and mental health initiative split*

Managers primarily focus on core business and service delivery Key Performance Indicators (KPIs). Fundamentally, occupational health and safety and mental health initiatives, even if their value is recognised, tend to be viewed as extraneous add-ons that are not part of core business. Hence, it is frequently difficult to achieve genuine buy-in, especially in a context of resource constraint and other competing managerial priorities.

The Review Team found that many members attributed mental health and suicide risk to the amount of pressure that police face every day in the performance of their jobs. As one member said:

> *"There is so much crime and we're tied to our computers." (VicPol member, 27 years)*

Some blame senior management and believe they should do more to garner further resources from government. Examples were provided where at some work sites, 25 percent of the staff could be on long service or maternity leave, secondment, light duties or WorkCover.

The Review Team acknowledges this situation but also considers that there are current examples of stations and VPS team environments where work pressures are effectively managed: these are much more likely to be supportive and engaging team environments with strong morale, and therefore less staff absenteeism and grievances etc.

In other organisations where there are KPIs around morale and engagement, the differences between team environments that are low and high on these characteristics are palpable. In these latter team environments, it is common to find much more active commitment to psychological health and safety issues.

Given the allocated timeframe for the Mental Health Review, it was beyond our scope to conduct any significant assessment of substantive workload issues.

### *Leaders lack awareness of how their behaviour impacts on employee wellbeing*

> *"You need to address cultural issues through values and you need to address behaviour." (Mental health nurse with 40 years' experience, mother of a member)*

> *"My Sergeant is awesome but sometimes orders are just barked at us - like we are dogs." (Senior Constable)*

Many leaders – across all industry sectors - lack awareness of how their leadership behaviours actually impact on the wellbeing of their direct reports. Leadership behaviours demonstrably influence levels of employee wellbeing (Page et. al., 2015)[14] . The Review Team concluded that Victoria Police is not exceptional in this sense, and being a culture grounded in operational practices, there has historically not been any significant focus on the role of people leadership capability.

14 Page KM et. al., (2015) The leaders guide to work-related stress. In Flourishing in Life, Work and Careers, Eds RJ Burke, KM Page & CL Cooper. Elgar: UK.

Further, the Review Team noted that it is not part of VicPol leadership culture to receive regular feedback on leadership behaviours:

> *"In a team, you don't want to challenge bad behaviour so you let it slide because you don't want to ostracise yourself in front of your manager." (VicPol member, 25 years)*
>
> *"I was treated like an absolute dog as I was an outsider. I'd had senior experience managing huge numbers of staff, did extra work but was told I'd never get above a VPS2." (VPS member)*

Increasing regular leadership feedback increases awareness and sensitivity to impacts on team member wellbeing. Historically to date, VicPol has not particularly embraced leadership feedback processes – which are common across high performing organisations in any industry sector.

From an adult learning principles perspective, feedback, reflection and enquiry-based methods, as well as coaching, are common practices utilised for achieving behaviour change, and tend to be a feature of effective leadership development programs. Further, 'action learning' methodologies (Marquardt et al., 2009)[15] above and beyond classroom didactic program delivery (i.e., undertaking team-based collaborative problem solving challenges in the field interspersed with didactic based sessions), are now common in leadership programs.

The Review Team noted that Victoria Police has the Hydra system at the Academy that enables high level simulation training to be undertaken. This training modality could be effectively deployed to develop and assess some people-focused leadership skills. However, this will still need to be embedded within a broader focus on action learning-based approaches where leaders implement in their team environments various team-based practices and collaborative problem solving activities. This is a cyclical process of training, action, review and coaching etc. over a timeframe of usually six to 12 months.

15 MJ Marquardt et. al., Action Learning for developing leaders. American Psychological Association: Washington DC (2009).

The Review Team also noted that there are unintended consequences linked with current promotional criteria and selection processes that need to be addressed: settings must be adjusted to take into account the 'how' of leader delivery; delivery at all costs, irrespective of the human casualties occurring along the way, should not be rewarded through promotion. How results are achieved should also be considered in promotional criteria and selection processes.

### *Role modelling for better or worse*

> *"Managers need to model the right behaviour." (VicPol member, 25 years)*

Leader day-to-day role modelling behaviour (often termed 'behavioural integrity' in the organisational behaviour literature) has a very significant impact on employee motivation and morale, and indirectly on mental health and wellbeing outcomes.

Employees make sub-conscious and conscious judgements every day about the genuineness of their leaders and leader attitudes towards various issues (e.g., how supportive a leader is in relation to staff wellbeing issues, the leaders' tolerance bandwidth for bad behaviour, and gender discrimination etc.), based on their day-to-day workplace experiences and observations.

There is research that suggests the failure of sophisticated workplace anti-sexual harassment programs occurs primarily due to the role modelling behaviour of leaders (Offerman et al, 2002)[16] . In these instances, employees perceive a discrepancy between verbally expressed support for such initiatives and leader non-verbal behaviour they interpret as indicating lack of support: the engagement is perceived as tokenistic and hence the overall message they interpret their leader communicating is that we only need to pay lip service to this type of 'trendy HR initiative'.

16 Offermann LR et. al., When leaders harass: the impact of target perceptions of organizational leadership and climate on harassment reporting and outcomes. Journal of Applied Psychology 2002 Oct; Vol. 87 (5)

# Chapter 5: Why Victoria Police Leadership Culture Needs to Change

*"Knee jerk responses, ladder climbing and ticking boxes is what our station leadership is all about." (VicPol member, 15 years)*

## *Common substrate*

Improved people leadership skills, as refracted through improved team climates, are associated with improvement in employee wellbeing levels, and reduction in mental health and psychological injury risk. Moreover, increased people leadership capability is associated with reduced gender discrimination and other counterproductive behaviours. People-focused leadership is a common substrate that positively contributes to all people-related outcomes including human resource metrics (e.g., absenteeism, grievances, lost time injuries etc.).

## *Building a house on wobbly foundations*

Without an underlying aligned and people-focused leadership culture, any mental health and wellbeing initiatives will struggle to gain traction and frequently end up falling over. This is not a Victoria Police specific issue: it is common across public and private sector organisations.

A common tendency is to invest in the latest training program available. This approach is akin to building a house on wobbly foundations. The question that needs to be confronted is, do we want to end up starting again in two years' time – and repeating the history of discarded initiatives looking to what new ideas and training programs we can latch onto because the underlying leadership cultural challenge has not been addressed?

In 2013, the VicPol Zero Harm program identified the need for the reintroduction of an organisation-wide leadership program as part of their 'cultural foundations' stream of work. However appetite at the time was limited and this did not occur.

## *What is people-focused leadership?*

All of the above considerations lead up to the need for greatly increased people-focused leadership. As discussed, this cannot be a stand-alone leadership quality but must be meaningfully embedded in developing strong team-based processes.

The scholarly leadership literature recurrently describes qualities and behaviours including: integrity (i.e., values-grounded behaviours and congruence between actions and words); role modelling expected behaviours and values; empathy; effective communication; self-awareness; demonstrating understanding of the issues employees face; respectful interactions e.g., listening well and talking to anyone (regardless of rank or level) in the same way; transparent decision-making; building clarity and accountability for results and behaviours; and proactively initiating supportive conversations with at-risk individuals. These factors, or variations on them, are included in most contemporary people leadership frameworks. They are central in scholarly theories of 'transformational', 'adaptive' 'resilient' 'supportive' leadership and 'emotional intelligence'; and are reflected in the current HR literature via the influential notion of 'trust leadership' (Covey, 2008)[17] .

Again, it must be reiterated that people-focused leadership is not an end in itself. To be effective, it must be invested in establishing, developing and maintaining the team-based processes that build support, clarity, engagement and learning (Hart et al, 2015)[18] .

Improving people-focused leadership capability and developing more supportive and engaging team environments must underpin the proposed Victoria Police Mental Health Strategy. In terms of managing operational incident exposure, there is only so much that can be done in terms of risk mitigation (e.g., training, incident protocols, protective equipment etc.).

17 JP Howell (2012). Snapshots of Great Leadership. London, GBR. Taylor and Francis; BM Bass & RE Riggio (2006) Transformational leadership. Mahwah, NJ: Lawrence Erlbaum Associates Publishers; SMR Covey (2008) The Speed of Trust, Free Press: New York; RR Kilburg (2012) Virtuous Leadership. American Psychological Association: Washington DC.
18 Hart PM, Cotton P, Scollay C. Flourishing at work. In Flourishing in Life, Work and Careers (2015) Eds RJ Burke, KM Page & CL Cooper. Elgar: UK

Accordingly, there needs to be an increased focus on building workplace protective factors and the key protective factor is people-focused leadership capability as reflected via the development of more positive and engaging work team environments.

## 5.2 Marked variability of people skills at middle level management

The Review Team concluded that there is an extremely high degree of variability in people skills at middle level management (e.g., Sergeant and Senior Sergeant levels). This was apparent from the large volume of comments reported by interviewees. These operational managers exert particular influence on frontline employees. There is an associated very wide bandwidth in terms of the 'psychosocial quality' of sworn and VPS work team environments across Victoria Police.

Hence this level of management should be a particular focus for leadership development and so-called 'soft skills' capability improvement, including initiating 'genuine' conversations with at-risk employees and supporting them in the workplace. This type of leadership development should be mandatory for all middle level managers. The Review Team noted that VEOHRC came to a similar conclusion.

> *"There are three groups: some Sergeants who refuse to engage in anything to do with people issues because they don't see it as part of their job; some Sergeants who are willing but ask – 'what should I do?; and a smaller group of Sergeants who are good at the people stuff." (Inspector)*

There are already existing training programs, developed by the Police Psychology Unit, around 'Critical Conversations' and 'Healthy Minds @ Work Managers' – but these programs are currently not mandatory. The Review Team understands that many Sergeants/Senior Sergeants have not participated in this type of training.

The high level of leader mobility that characterises the Victoria Police operating environment at the station level is also considered to be a significant contributing factor to 'people-related problems'. It is the exposure to different and contrasting leadership styles and how directive a leader is; wide variability in leader attitudes towards wellbeing issues, and leader role modelling around these issues - that contributes to reductions in morale, disengagement, and individuals re-evaluating their operational experiences more negatively (and hence more likely to progress down the 'erosive stress pathway').

In mature organisations, the bandwidth or variability around people-focused leadership capability is much less, and correspondingly there is reduced people-related risk. In this type of organisational environment, mobility in leadership roles becomes less of a problem. This is another reason why the proposed leadership culture change/'leadership uplift' program will be critical to the success of the Victoria Police Mental Health Strategy. Paraphrasing the quote above, *VicPol needs many more Sergeants who are good at the people stuff, and no Sergeants who don't see managing the welfare of their staff as part of their job.*

# Chapter 5: Why Victoria Police Leadership Culture Needs to Change

## 5.3 Leadership development and the need for an overarching people leadership framework

The Review Team noted that there is some mental health and wellbeing related content in various programs in the leadership training curriculum: e.g., Leadership and you; Professional conversations; Managing group behaviour; Mental health and custody; Mental health in the community; Death notifications; etc.

However, the Review Team concluded that a lot of the content has been developed through different, often disparate, lenses and hence lacks any coherence and consistency in terms of the threading of messages through various programs. Moreover, there does not appear to be any (people-oriented) overarching leadership framework. In the opinion of the Review Team, the content of leadership programs needs to be revised, and anchored around a coherent overarching leadership framework. This should also involve input from health and wellbeing areas to develop a coherent framework with clear accountabilities, to enable comprehensive, consistent and complementary program development.

Thus far we have described the nature of the indicated leadership culture change and some identified training needs regarding so-called 'soft skills'. Specifically, one of the skills required is the ability to have "candid conversations" regarding performance issues and challenging behaviours but also with understanding of early indicators of stress and mental health issues. One member related: *"I've taught myself to have these conversations because the tool kit is not deep enough about mental health."* These skills can be learned and practiced and as one member said after doing such a course, *"it has made me a better husband and a parent."*

The ability to reflect and empathise is also important for managers who will need to 'work with' any member who is on a Return-to-Work program.

A number of respondents commented on the lack of empathy with this one particularly pithy observation noted:

> *"I don't know if you can teach it (empathy) but there seems to be many police who would be on the autism spectrum." (VicPol member, 27 years)*

A number of interviewees suggested that when leaders are being considered for promotion there should be:

> *"psychological testing to determine if they have the mental capacity to deal with other people." (VicPol member, 27 years)*

Otherwise, promotional pathways can result in:

> *"process people, not people and this creates a problem." (VicPol member, 28 years)*

These comments point towards the need for increased accountabilities around people-related outcomes and recognition of the role of feedback-related processes – see section below for further discussion.

## 5.4 Undertaking leadership culture change

Fundamentally, any substantive change in leadership culture must start with the senior leadership group. The senior leadership of Victoria Police must be aligned with and role model the expected supportive approach and more engaging leadership behaviours to managing employees generally, and more specifically those with mental health-related issues.

Here we can refer to the journey that the Australian Defence Force (ADF) has embarked on since 2011, as a relevant case study. There are parallels with Victoria Police in terms of Defence undertaking a number of reviews that found significant problems with sexual harassment and gender discrimination, and concurrently, reporting of increasing concerns about mental health issues. The ADF concluded that, in addition to the development of a mental health

strategy, fundamental leadership culture change was required to effectively address sexual harassment and related issues, as well as support the mental health strategy. The leadership culture change program they have embarked on is detailed in *Pathways to Change* (ADF, 2011). This document indicates that change must start with holding senior leaders to a higher level of accountability in terms of expected changes and role modelling behaviours. Defence has recently concluded its first iteration of their mental health strategy (2011 to 2015) and are currently in the process of formulating their second strategy. Leadership culture change remains a priority but progress has been made (Morton, 2016)[19] .

Such leadership culture change will no doubt provoke some push back: e.g., Where are we heading – creating ineffectual 'touchy feely' officers? VEOHRC (2015) noted the reliance of the ideal officer cultural touchstone on masculinity stereotypes: 'strong, assertive, resilient, thick-skinned and a suck it up' approach. Or, as Tuckey et al., (2012, ibid) further described, 'emotional suppression' 'invulnerability' and 'lack of understanding, support and acknowledgement of psychological health and safety'.

These types of qualities certainly appear to be the tacit touchstone for norms governing how a police officer should behave. VEOHRC suggested that the ideal officer profile needs to be decoupled from reliance on such traditional masculine characteristics.

A number of responses from female members noted that there may also be additional stress for them should they choose to admit they are not coping. One 22 year VicPol member said she would, "*rather go into the toilet and have a little cry or say to myself - pull your big panties on.*" A 38 year male member acknowledged that, "*things won't really change until there are more women.*"

Also consider, for example, the massive change in the ADF prompted by bringing women to the frontline. Having defined the physical fitness standards, the psychological characteristics required (e.g., in terms of decision-making capacity under pressure etc.), then anyone – regardless of gender or race - is accepted if they meet the requisite criteria. The backlash has now subsided and it is more or less a non-issue.

Irrespective of further reflection on this central issue, culture change occurs through 'leading from the top' (and hence the initial focus on the senior leadership group) as well as implementing the organisation-wide development and training initiatives that result in more positive and engaging people environments. Further, progress in the direction of increasing accountabilities is crucial (e.g., via local leader KPIs and potentially from fine-grained employee engagement surveys that may be used to drive measurable improvement)[20] .

### *Sexual Offences and Child Abuse Investigative Team (SOCIT) Case Study*

In considering this general issue, we make some observations about how the SOCIT group seems to sit within the wider Victoria Police culture. The Victoria Police Corporate Plan 2015 noted the need for, "greater attention to victimisation" and "providing an appropriate victim response" (p.27). Moreover, "it is expected that the reporting rates of child abuse, both historic and current will increase in the coming years" (p.13). Such considerations have led to the formation of the SOCITs.

19 See footnote 5.

20 As a further example of this type of leadership development, we note another example from a different industry sector in Victoria: the Victorian Education Department's Bastow Institute. This body coordinates all leadership development and offers a range of action learning and training programs that build a range of people-focused and task focused capabilities. These programs are anchored in an organisation-wide framework that describes desired leader behaviours and school based cultures, and how these relate to government policy.

# Chapter 5: Why Victoria Police Leadership Culture Needs to Change

Based on consultation with Sexual Offences and Child Abuse Team (SOCAT), from Family Violence Command, and information gleaned from interviews with SOCITs, an ideal SOCIT, in addition to investigative skills, requires qualities of strong empathy, openness, listening skills and patience. These are not particularly traditional police officer traits. The Review Team noted numerous comments made in interviews with SOCITs to the effect that they often perceive they are treated as "second class citizens" in relation to the mainstream culture:

> *"It's not viewed as real police work."*

> *"The Inspector often allocates our car for other 'real police work' and I have to find alternative transport to get to court and meetings".*

As part of the leadership culture change being proposed, and the development of an overarching leadership framework, some reflection and re-clarification should occur regarding the qualities that define effective police officers and leaders in the context of ever evolving community expectations and the increasing organisational focus on victim-centric policing approaches. SOCIT issues are further discussed in Chapter 8.

## 5.5 Excessive tolerance margin for bad behaviour

> *"I was going through mental hell after my marriage broke down. My supervisor told me 'if you want to get emptied out, go to – [brothel named]'. I was already very fragile." (VicPol member, 22 years)*

Currently in Victoria Police, the Review Team found that there is an excessively wide tolerance margin for 'bad behaviours' (i.e., incivility and counterproductive behaviours). Values and Expected Behaviours are not a prominent element in day-to-day team functioning. Of course, there are many team environments characterised by respectful interactions, but this is not the norm.

It seems that individuals are generally not held accountable for behaviours unless transgressing what is effectively a criminal threshold. VEOHRC also reached the same conclusion and noted, within the context of its terms of reference, a climate of "everyday sexism". Moreover, there is no behavioural component included in the current performance appraisal system and individuals are not held accountable for multiple low level inappropriate behaviours.

Ambulance Victoria (AV) recognised this as a key challenge some four or five years ago. Its leadership culture had hitherto been narrowly oriented towards clinical KPIs and ambulance response times. There was an excessively wide tolerance margin for poor behaviour because leaders tended to be technically oriented and had minimal focus on people issues (this is often referred to in the leadership literature as the Laissez-faire leadership style). AV recognised a capacity gap in middle level managers and, since that time, has implemented frontline manager training; a focus on reducing 'incivility' and narrowing the tolerance bandwidth for bad behaviours; and Safety First – a program that increases accountability at all levels of leadership for the psychological safety of employees.

As noted elsewhere, this type of laissez-faire leadership enabled wide tolerance in team environments for bad behaviour is associated with an increased risk for mental health-related problems and psychological injury. Where respectful interactions are the norm and individuals are held accountable for behaving within the terms of a Values and Expected Behaviours framework, this constitutes a protective factor in relation to the mental health and wellbeing of employees.

Hence, as part of the leadership culture change proposed, revamping and relaunching Victoria Police Values and Expected Behaviours is an integral element. VEOHRC also made the same recommendation.

The Review Team further recommends that 'Safety' be included as an additional value – to appropriately reflect the importance that Victoria Police places on the physical and psychological health and safety of all employees. It is acknowledged that VicPol has undertaken a number of initiatives over the years in this cultural space. That further effort is still required only reflects the size and depth of the challenge.

Linked with this, it is essential that weightings be introduced in all performance appraisal reviews to adequately reflect increased accountability for managing people-related issues. This includes actively managing inappropriate workplace behaviours, as well as supporting individuals with mental health issues and those returning to work. As noted earlier, people-focused leadership is a common substrate that positively impacts on multiple people issues including discrimination, harassment, mental health, wellbeing and psychological injury. Hence, ideally from a prevention perspective, VicPol should work towards *introducing accountability at the local level for employee morale and engagement.*

## 5.6 The potential of safe-t-net and leadership

> *"It will be a good system because it captures everything and the information moves with the person." (VicPol member, 26 years)*

> *"Safe-t-net sounds good and it will be possible to leverage off it." (VicPol member, 18 years)*

The Review Team found that the new safe-t-net program (a sophisticated incident register and psychosocial risk management system developed as a key initiative under the Zero Harm program) and currently being piloted, has huge potential for improving mental health and wellbeing outcomes across Victoria Police.

The safe-t-net program will be supported by online training for all employees with a specific program for managers. Guidelines and practical support materials for wellbeing conversations, along with general supporting documentation will be available. A state-wide roadshow is currently underway, demonstrating the system and outlining the roles and responsibilities of managers. Prior to the introduction of safe-t-net into any workplace, at least 80 percent of the local management will need to have completed the safe-t-net all employee and manager online programs and those locations with higher mental health literacy will be allocated safe-t-net in the earlier stages of rollout.

Some active locations have devised safe-t-net rollout teams and have engaged in further face-to-face mental health training in readiness; however these have been the exceptions rather than the norm.

The underlying premise of the safe-t-net conversations is simple and designed to actively address mental health and wellbeing issues. Managers who require additional assistance will initially be encouraged to undertake existing critical conversation training. Once the system is fully active post July 2016, a targeted and comprehensive safe-t-net training program will be developed to reinforce organisation-wide reception and leadership skills, utilising video examples and experiential learning. Safe-t-net will be supported by an ongoing core unit, to ensure active management and monitoring of the system, its use and impact.

Safe-t-net will be underpinned by an organisation-wide policy as the mandatory and single employee wellbeing 'risk' register at Victoria Police to support occupational health and safety risk identification, and support wellbeing.

# Chapter 5: Why Victoria Police Leadership Culture Needs to Change

The Review Team concluded that Victoria Police has under-estimated the indicated culture change and people leadership capability uplift requirements that are needed to make this program operate effectively. As per earlier comments, there is a need to support the safe-t-net program with ongoing and curriculum integrated training. Safe-t-net needs to be visually role-modelled from all levels of senior leadership[21] .

The leadership culture change program described above is considered to be an essential foundation to support mental health and wellbeing initiatives and ensure their potential is fully realised. In any industry sector, this type of culture change program typically requires a three to five year timeframe. This program is also a necessary condition for building workplace protective factors to offset the impact of operational incident exposure.

## 5.7 Accountability

In passing, the Review Team notes that in other industry sectors, there is a trend for organisational/ leadership culture change programs to be driven by fine-grained accountability mechanisms, including increasing local accountabilities for people-related outcomes. In addition to any people-related KPIs, this can be afforded by an evidence-based culture/ climate survey that measures employee experience of key organisational factors and specific leadership behaviours that are known to be key drivers of wellbeing and performance-related outcomes.

In our view, Victoria Police may not be quite ready for such an initiative at this time – but this should be re-considered, depending on progress with the VEOHRC Report recommendations and the VicPol Mental Health Strategy, over the next 12 to 24 months. Such surveys, with police benchmark databases, are available. Ideally, such assessments should be an integral component of an organisational change strategy.

In conclusion, the Review Team can here only note that significant culture change is difficult and hence the necessity for substantive focus on accountability mechanisms at all levels to achieve this.

The Review Team finally notes that the ADF has also identified this as an ongoing challenge with its organisation-wide culture change program.

## 5.8 Wellbeing checks and the role of leaders

By virtue of the occupational health and safety legal requirement to maintain a psychologically safe work environment, leaders have responsibility for the welfare of their direct reports (this is extant and not anything new). This does not mean that they need to become counsellors and diagnosticians: but it does mean, as people leaders, that they should be alert to early warning signs and proactively engage with at-risk employees initiating a supportive and 'genuine' conversation, with the main purpose of facilitating access to relevant help resources and problem solving any work issues. The safe-t-net system is expected to facilitate initiation of these types of conversations.

We have described in the previous chapter the key elements of mental health literacy training, including training in undertaking these types of conversations. As Victoria Police progressively becomes a more 'mentally healthy workplace' this type of informal wellbeing check conversation should become the norm. We also note that leaders with high level people-focused leadership capability tend to already do this, irrespective of mental health literacy training.

The Review Team sought feedback on mandatory counselling following an incident and as complementary to the existing Psychological First Aid and Peer Support assistance. Overwhelmingly, this was seen as desirable:

> *"It might be seen as a whole lot of rubbish, but there's a bit of bravado and one on one, it can be quite valuable."*

21 We discuss this issue further in Chapter 7 and here note that the need to buttress safe-t-net and prevent it falling over supports the need for an organisation-wide leadership culture change.

*"This should be across the board so no one would feel personally targeted." (VicPol member, 27 years)*

*"Previously, I thought it was silly, but after having an experience when a psychologist offered services, no one felt singled out." (VicPol member, 39 years)*

This issue is further discussed in Chapter 7.

## 5.9 People functions considered from a structural perspective

The Review Team also observed that people functions are distributed across a number of commands. For example, a number of organisational development functions are not under corporate human resources – which is more typical in most organisations.

From the perspective of substantively improving mental health and wellbeing outcomes, there needs to be much greater alignment and coordination of these people functions than is possible when they are effectively operating under completely separate management structures. It is apparent that to deliver the outcomes of this review along with the recommendations set out in the VEOHRC report, the alignment and integration of the various people-related commands has never been more important.

Ideally this would see the Human Resource Department, People Development Command and Professional Standards Command functions brought together under the leadership of an Executive Command member who would have full accountability for driving the strategic people-related agenda, including leadership capability uplift, employee life cycle management and associated people-related support services.

If this matter is not addressed the Review Team has a concern that the effectiveness and sustainability of the organisational change required to achieve the outcomes reflected in this review and the VEOHRC Report, may be at risk. Hence, the Review Team endorses, from the mental health improvement perspective, the VEOHRC recommendation that people functions should be brought together under one executive portfolio.

# Chapter 5: Why Victoria Police Leadership Culture Needs to Change

## Recommendation:

6. The 'leadership uplift' program should commence with a series of Executive Command workshop sessions led by an expert people leadership consultant, and include mental health literacy content, directed towards achieving senior leadership team buy-in and alignment around the Mental Health Strategy (which will be developed on the basis of this report). The program should also include wellbeing/mental fitness being re-positioned as foundational (on the same level as operational training skills) and increased accountability and expectations for role modelling the indicated changes, values and expected behaviours.
7. Bring together related people functions into one executive portfolio to achieve the integration and co-ordination of functions that is required to achieve the needed culture change.
8. Reorganise and update all leadership programs around an overarching people oriented leadership framework, ensuring consistency of messaging across programs. Mental health literacy content should also be embedded and examinable as a mandatory component in all leadership development programs, especially sergeant and senior sergeant levels, as well as training in undertaking supportive conversations. Attendance at a minimum number of such programs (e.g., at least one per year) could be included in Professional and Development Assessments for accountability purposes.
9. Introduce appropriate weightings in the performance appraisal system to increase a focus on expected behaviours, and management of inappropriate behaviours in addition to standard performance Key Performance Indicators.
10. Revamp and relaunch Victoria Police Values and Expected Behaviours. It is recommended that 'Safety' be included as an additional value.
11. Consider an organisational climate survey for the next iteration of the VicPol culture change program to assist in driving increased people-related accountabilities. In the interim, a 'pulse survey' (as noted in Chapter 4) should assist.

## What would success look like?

On an individual level, KPIs would be seen as part of the performance appraisal and the promotion processes. These would be discussed during the appraisal and promotional process to reinforce their importance and relevance to what is required of managers. For VicPol as an organisation, this culture change program could be monitored with the use of the 'pulse survey' noted in Chapter 4 (note that a key indicator for a 'mentally healthy workplace' is that frontline staff across an organisation report confidence in being supported in the workplace if they or a colleague experienced a mental health problem or psychological injury).

*"My very first job was the death of a child. My Sergeant moved the box of tissues away from me and told me that I needed to suck it up."*

# Chapter 6: Victoria Police Mental Health and Wellbeing Services

***Key findings:***

- *No major service capability gaps were identified by the Review Team. Existing health and support services were found to be performing well, within the bounds of ongoing major resource constraints.*
- *Police Psychology and Welfare Services perform a vital role that is significantly under-resourced; currently to the point of compromising the effectiveness of these services. Both of these services require an increase in Full Time Equivalent positions.*
- *Medical Advisory Unit and the Police Psychology Unit should be co-located under the same Command structure.*
- *There is an increasing need for psychological fitness for duty assessments – conducted by health professionals who have this specific training.*
- *VicPol should further build in-house mental health specialist capability, particularly to undertake complex assessments and provide advice to other health services staff.*
- *There is an urgent need to move from a paper-based system to an e-based client management system to more effectively manage referrals, maintain health information in one location, and follow-up.*
- *Issues around confidentiality of Victoria Police health services, particularly Police Psychology Unit and Welfare Services were found to be the subject of some misinformation.*

The Review Team did not identify any major gaps in current Victoria Police mental health and wellbeing services. There were indications of a need for further development of various services, updating various training offerings, and changing some structural impediments to achieving better service alignment and coordination.

Moreover, current services were found to be severely restricted in focusing on the increasing need for early intervention and prevention initiatives, through lack of resourcing. Because of this, they continue to be largely reactive. Improving mental health and wellbeing outcomes and reducing suicide risk, requires an increased upstream focus on prevention and early intervention initiatives. In relation to this, a major problem was identified around workload pressures and resourcing. Current services are straining to meet increasing service demand.

## 6.1 Current service profile

*Please note; the below Full Time Equivalents (FTEs) variously include project officer and administrative support staff.*

- Medical Advisory Unit – 10.9 FTE

Current services provided include: medical fitness for duty, recruit medicals, squad medicals / statutory medical assessments, alcohol and other drug in the workplace program, infectious disease advice line and general medical advice to internal stakeholders.

- Police Psychology Unit - 18.6 FTE

Current services provided include: psychological counselling and treatment, referral, case management, management consultation, risk assessment and crisis support, critical incident response, liaison with treating practitioners and other organisational systems, and education and training services.

• Welfare Services – 10.8 FTE

Current services provided include: provision of support, information, and referrals for members and their immediate families, including internal witness protection. There is also a 24/7 crisis support service provided via the Support Line.

• Peer Support – 5 FTE

Current services provided include provision of initial support to members in response to notifications, requests from members, manager requests; and making referrals. Peers undertake an initial five day training program. There is a one day refresher course. There are currently approximately 600 sworn peer support officers and one psychologist.

• Injury Management and WorkCover - 27.9 FTE

Current services include injury management services, claims management and monitoring, and liaison with the WorkSafe agent.

• Internal Witness Support – 3 FTE

Current services are focused on provision of support to internal witnesses.

• Chaplaincy (one full time chaplain and approximately 60 volunteer chaplains)

Current services include the provision of pastoral care and spiritual support. The VicPol chaplaincy service is multicultural and has providers covering eight of the major world faiths. The volunteer chaplains typically provide VicPol with three hours service each week.

• Employee Assistance Program

Contracted external provider offers general counselling services for members. Access is triaged via Police Psychology Unit.

The Police Association (TPA) also offers welfare services and an Employee Assistance Program (contracted external provider that is directly accessed).

## 6.2 Service comparisons

- Queensland Police has 67 FTE health, welfare and chaplain providers (including 26 FTE psychologists) - and a workforce of approximately 15,000. This equates roughly to a health and wellbeing staff ratio of 1:224 employees.
- New South Wales Police has 12 FTE psychologists - and a workforce of approximately 16,600. There are also psychologists in the recruitment group.
- Western Australia Police has 32.4 FTE health, welfare and OH&S service providers, (including 6.5 FTE Clinical Psychologists) - and a workforce of approximately 8,200. This equates roughly to a health and wellbeing staff ratio of 1:253 employees.
- The VicPol psychology and welfare staff to employee ratio is currently 1:612 for a workforce of approximately 18,000. The increase in FTE positions (by 11 psychologists and six welfare staff) will shift this ratio to 1:388 employees.

N.B. This provides only a very rudimentary cross jurisdiction comparison. The health and wellbeing staffing information available from different jurisdictions is reported in different ways, and different jurisdictions have different service configurations: there is a varying mix of services delivered by each group of service providers. Western Australia has additional psychologists in a separate recruitment division.

To reiterate, the increase in psychologist and welfare FTEs is warranted by the additional contribution they will make to the organisation-wide mental health literacy program content development and delivery, leadership uplift, and safe-t-net involvement; continuing increasing demand for mental health screening assessments, undertaking psychological fitness for duty assessments, increased advisory and coaching services, and increased assistance with safe-t-net, assisting with intervention services for identified at-risk stations and individual leaders; and increased indicated support for Sexual Offences and Child Abuse Investigation Teams etc.

# Chapter 6: Victoria Police Mental Health and Wellbeing Services

The welfare officers are particularly indicated to address current understaffing due to documented increased service requests, and trialling the single point of contact approach, in conjunction with injury management consultants.

## 6.3 Feedback on existing services

Overall, the existing services are well received. The Review Team did not identify any major gaps in current mental health and wellbeing services. A hitherto significant gap in the early intervention space has seen the recent introduction of the Trauma Group Pilot Program aimed at engaging individuals with emergent trauma-related symptomatology. In the opinion of the Review Team, this program will need to be expanded and further resourced (see Chapter 7 for further comment) as it has the potential to address key early intervention needs.

There were a small but significant number of members who reported feeling that their contact from Psychology and Welfare services following exposure to incidents was perfunctory (e.g., *"ticking the box"*). Some interviewees spoke of being informed that they would be contacted but that follow up contact never eventuated.

The Review Team concluded that this is highly likely to be more a reflection of workload and resourcing pressures rather than a capability issue or other service inadequacy/lack of care. Further, it is also clearly linked with the archaic paper-based systems that support current service delivery.

## 6.4 Management of health information

Each unit (Psychology, Welfare, Peer Support and Internal Witness Support Unit) currently has standalone Microsoft (MS) Access databases to capture information, as well as relying on spreadsheets and manual paper based record keeping. These databases are based on versions developed originally for Welfare Services and are therefore not entirely fit for purpose for the other units. Data for the overall group is fragmented, with no integration across the group or with other Victoria Police systems.

The reliance on paper files and lack of any contemporary electronic patient management system increases the risk that indicated follow-up contacts can be missed, 'falling between the cracks'. Importantly, current systems do not allow any checking on relevant historical contacts in one place an individual may have had with any of the services.

The Review Team noted that the Australian Defence Force has implemented a fully integrated e-medical and psychology file system. This system enables medical and psychology staff to better clinically assess new referrals, because they have ready access to the relevant previous history of contacts with health services etc. The Review Team recommends that Victoria Police implement an integrated client management system to support the proposed Mental Health Strategy.

## 6.5 Demand on services and the role of professional/peer support

In the wake of the VEOHRC report, there has been increased demand as individuals feel more confident in coming forward, because they are starting to believe that the organisational environment will now be less invalidating of their experience of counterproductive behaviours (e.g., bullying and sexual harassment). The Review expects the demand for psychology services to continue to increase in this respect. Further, the Review Team recommendations around mental health literacy (see Chapter 4) will require additional resourcing.

The Review Team noted that the services of Police Psychology Unit are well regarded:

> *"I've always found them to be extremely helpful." (VicPol member, 31 years)*

> *"I've referred to it in the past and they've been great and it should be extended to rural areas." (VicPol member, 17 years)*

*"VicPol provides ample services for members and is fantastic and they do what they say." (VicPol member, 18 years)*

*"Peer support do good work, but who looks after them?" (Sergeant)*

Another indication of the strain on services is the current turnover and sick leave profile: nearly half of Police Psychology Unit staff have either recently resigned or gone on sick leave over the past six months (two resignations and two on stress-related sick leave). Whilst it is inappropriate to comment on individual circumstances, it is clear that workload pressures have been a significant contributing factor. Sick leave is also reported to be higher following attendance at critical incidents. This is also suggestive that the workload pressures on Police Psychology now constitute an occupational health and safety risk.

The Review Team concluded that there is an urgent need to increase Psychology Full Time Equivalent positions. This is also linked with recommendations regarding additional services that Police Psychology Unit should deliver (e.g., including additional mental health screening and augmented mental health literacy training – this is further discussed in Chapter 7).

One further issue to comment on here is that the Review Team noted reductions in availability of professional supervision for psychologists, welfare and peer support officers, as a result of unrelenting ongoing resourcing pressures. Professional supervision is not only of benefit for personal professional development purposes, but is also health protective: it directly contributes to reducing the effects of vicarious trauma.

Victoria Police health service and support providers are as significantly exposed to the risk of vicarious trauma as are those employees working with victims of child abuse and online child exploitation materials. The question was raised by numerous interviewees, 'Who cares for the carers'? One example that was provided indicated how stretched Peer Support Officers can be:

*"I attended an incident where a member had suicided. What was actually needed was a three pronged approach - one person for the critical incident response, one to handle the grief response at the station and one for the family response. The job did not end there; there was further follow-up required as there can be with any major trauma." (VicPol member, 31 years)*

It is acknowledged that this may be difficult to quantify in pure economic terms, but a minimal level of professional supervision is considered to be vital to maintain the mental health and wellbeing of these service providers, and reduce occupational health and safety risk.

The Review Team received positive feedback for the Peer Support Program:

*"Absolutely fantastic." (VicPol member, 40 years)*

*"They do a fantastic job." (VicPol retired chaplain)*

However, there were also some concerns expressed:

*"Some do it to look good and might not volunteer for the right reasons." (VicPol member 22 years commenting on past issues of predatory behaviour)*

*"I have concerns as I'm not sure all the right people work there." (VicPol member, 17 years)*

To strengthen the Peer Support Network, minimal level professional and peer supervision for Peer Support Officers (and Welfare Officers) is a necessary requirement. The Review Team considers that this is essential to: (a) protect the wellbeing of service providers, as well as (b) maintain the quality of service provision. Experience in some other sectors has shown that where all supervision and refresher type training is ceased, peer support networks can degenerate into an ineffective service with numerous rogue elements.

# Chapter 6: Victoria Police Mental Health and Wellbeing Services

The current VicPol Peer Support Network is managed by one Psychologist – who was consistently reported to be doing an outstanding job. The Review Team noted some concern about whether the functioning of the whole network is overtly reliant on one individual. It is essential that the Peer Support Network be adequately resourced to maintain the quality of services.

## 6.6 Medical and psychological services, fitness for duty assessments and in-house specialist mental health expertise

Medical and psychology services currently operate under two separate commands. In the opinion of the Review Team, this inhibits the close collaboration that is needed to effectively address current organisational mental health and suicide risk issues. Currently, many at-risk individuals are managed entirely separately by both services with no or negligible interaction. Accordingly, the Review Team recommends that, structurally, these two services be brought together under the same Division of the Human Resource Department.

Further, the Review Team noted that some delegations, e.g., fitness for duty assessments (or Direction to Attend) sit exclusively under the Medical Advisory Unit. This is considered to be out-dated and not reflective of contemporary mental health practice.

For example, the Commonwealth Public Service Act was amended in 2013 to include specialist psychologists under the definition of 'nominated medical practitioner', in recognition of the fact that many indicated fitness for duty assessments are primarily psychological in nature and that medical practitioners, apart from psychiatrists, have variable skill levels in conducting what are effectively psychological assessments. As a further example, Centrelink has changed its criteria for acceptance of Disability Support Pension claims. It no longer accepts a general medical practitioner diagnosis of any mental health disorder, unless endorsed by either a Psychiatrist or Clinical Psychologist.

In other police jurisdictions, such as New South Wales and Western Australia, medical officers focus on physical fitness for duty assessments and mental health related fitness assessments are conducted by psychologists and psychiatrists.

The Review Team also reviewed the International Association of Police Chiefs (2013) guidelines on psychological fitness for duty assessments, which recommend minimal examiner qualifications of a licensed psychologist with relevant training or a licensed psychiatrist.

Accordingly, the Review Team recommends that the Victoria Police Act be amended to include 'psychologists with relevant specialist training' to meet the demand for psychological fitness for duty assessments.

The Direction to Attend (DTA) process was consistently portrayed by interviewees who made comments about it as a negative process. The Police Association has also voiced serious concerns. More specifically, the concern is that receiving a DTA is the beginning of an inevitable exit process from Victoria Police employment. This perception is not supported by the facts: some 70 percent of individuals attending a DTA in VicPol do return to work or maintain suitable employment[22]. It is only approximately 20 percent of DTA assessed employees who are directed to retire on medical ill health grounds.

The negative view of fitness for duty processes is not peculiar to Victoria Police; it is reported across many public and private sector organisations. A major contributing factor to this view is that fitness for duty assessments are commonly initiated a lot later than when they are optimally indicated. Because of this there is an increased likelihood that the individual will be assessed as being no longer able to perform the inherent requirements of their job. Hence there is some validity to this concern.

22 Based on information provided by the VicPol Medical Advisory Unit

Fitness for duty (or DTA) referrals need to occur earlier as appropriately timed fitness for duty assessments can contribute to accessing appropriate treatment when it can be most effective. When they are initiated earlier, the experience of other organisations is that many more individuals are able to return to full functioning because they access appropriate treatment earlier. The Review Team expects that, as Victoria Police becomes a more 'mentally healthy workplace', the recognition of early warning signs will improve, and early help seeking behaviour will increase, and hence earlier referrals for a DTA will occur.

The Review Team further recommends that in-house specialist mental health capability be increased. We note that the Medical Advisory Unit has recently been considering appointment of a sessional Psychiatrist. Overall, the Review Team supports this and recommends that two positions be created: a sessional Psychiatrist position and a 0.5 Clinical Psychologist position in the Police Psychology Unit, to undertake complex clinical assessments; and provide specialist advice, liaison, supervision and consultation services to other internal service providers to continue to build in-house mental health capability.

Psychiatry and/or clinical psychology assessments should be prioritised for all 'complex' cases. Further, those service providers who undertake assessments should operate distinctly from, e.g., psychologists who deliver treatment and counselling services, to minimise any potential conflict of interest. The placement of the sessional Psychiatrist and Clinical Psychologist positions should be considered when determining the service delivery model as part of the VicPol Mental Health Strategy.

## 6.7 Confidentiality issues and provision of reports by health service providers

The Review Team noted some comments suggesting that confidentiality breaches in relation to Victoria Police mental health and wellbeing services are common, particularly in relation to services provided in the wake of an operational (or critical) incident. Firstly, regarding any psychology services, we note that the same professional obligations apply irrespective of whether the provider is from the internal Police Psychology Unit, or external Employee Assistance Program for Victoria Police or The Police Association.

The Australian Health Professionals Registration Authority (AHPRA) requires all Psychologists to observe client confidentiality. This confidentiality may only be breached in circumstances where there is an identified risk of harm to self or others or criminal activity. Breaches of confidentiality are treated very seriously by AHPRA. Otherwise, a Psychologist cannot do anything with a client's health information without their written consent. In a legal context, a subpoena can override confidentiality requirements, but this applies equally to all providers, irrespective of who may be sponsoring their services.

Welfare Services does record the basic information that is required in order to conduct an effective case management approach. The Review Team did not identify any problems with Welfare staff handling of employee health information.

The other issue that has been raised – and this seems to be the only substantive issue the Review Team could identify here – is that if, for example, a member talks to Police Psychology or Welfare following a critical incident and discloses they are already seeing a community-based psychologist, then potentially, if there is any ensuing investigation process, the investigators may then be able to seek information from the external treater, subject to standard legal processes.

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If that member did not speak with Police Psychology or Welfare following the incident, then this information may not come to light to be pursued through any investigative process. To equate this with 'Police Psychology and Welfare Services are not confidential', is in the opinion of the Review Team, promoting misinformation.

The Review Team has had, as its overriding priority, improving mental health and wellbeing outcomes for all Victoria Police employees. The current Police Psychology and Welfare practices around information gathering were considered to be entirely appropriate and consistent with reasonable expectations of health service providers and the Health Records Act (2001).

There were no indications that any change is indicated (apart from the need to develop a fully integrated e-based client health information system – as, for example, the ADF uses). We appreciate the point about investigators potentially accessing information – but note that our priority focus is on enhancing prevention and early intervention initiatives where, as this is progressed, such an issue should become largely redundant.

A related issue was raised that, reportedly the VicPol Employee Assistance Service (EAS) won't provide any report, but The Police Association EAS will. Seeking a report from an EAS provider, requested by the individual who attended the service should not be an issue. Many EAS providers are very cautious about provision of reports, because they are concerned about any perceived breach of their confidentiality firewall, or perception that they may not be independent from the contracting organisation. However, this does not necessarily need to be compromised, and overall service integrity can be preserved where there is a clearly delineated process for acquiring a report, reliant primarily on the informed consent of the individual.

A related issue is EAS provider reluctance to provide reports because they are often asked to comment on causation, e.g., where there may be liability issues to determine in a workers compensation context. This is simply addressed by the provider indicating that they can only comment on presenting symptoms, specific services provided and response to the counselling. EAS providers can reasonably indicate that they have not undertaken a detailed clinical assessment and hence are not in an appropriate position to comment on causation (i.e., they typically only hear the client's narrative of the causes and do not have any collateral information available). It is entirely appropriate to indicate this in a report.

In conclusion, any EAS provider should be able to provide a report, as indicated by the parameters discussed above, in response to the request of the individual that undertook these services.

## 6.8 Current Employee Assistance Service triage arrangements

The Review Team did not identify any particular need for the current Police Psychology Unit triage arrangements for referral to an external EAS to be changed.

However, it did conclude that there is an urgent need for increasing early access to mental health specialists (e.g., psychiatrists and clinical psychologists), above and beyond standard EAS counselling services. Hence, the current panel should be expanded to take this into account. A recommendation to establish a specialist provider network for early intervention is discussed in Chapter 7.

## 6.9 Victoria Police and The Police Association

The Review Team did note with some bewilderment, apparent adversarial elements in the working relationship around health information between Victoria Police and The Police Association. The Review Team noted common objectives in improving mental health and wellbeing outcomes but that, somehow, there is not the collaboration occurring that is seen in other sectors.

For example, Ambulance Victoria (AV) and United Voice are currently working 'hand in glove' on a wellbeing oversight working group focused on reducing mental health risks and improving the wellbeing of all AV employees – and have achieved considerable progress.

Of some concern, the Review Team was told by a number of interviewees (more than 10, at separate times and spontaneously reported), that they had explicitly been told by a TPA representative not to engage with Police Psychology or Welfare. It is the opinion of the Review Team that this is highly inappropriate and in some circumstances may actually increase mental health risk to members.

*"The TPA advises people to use PTSD, which is a cynical approach." (VicPol member, 38 years)*

*"Some with PTSD may be having issues in everything in their lives and the advice from the TPA is towards a financial outcome." (VicPol member, 36 years)*

*"Because I wouldn't go on WorkCover, the TPA didn't want to do anything." (VicPol member, 8 years)*

We make no comment about industrial issues and can only recommend that renewed efforts be made by both parties, in the common interest of improving mental health and wellbeing outcomes for all Victoria Police employees, to work more collaboratively.

### Recommendation:

12. **Increase Police Psychology Unit Full Time Equivalent (FTE) positions. This needs to take into account additional service demands such as increased mental health screenings, provision of professional supervision services, increased coaching and leader support initiatives, workshop content updates and mental health literacy program delivery requirements. It is estimated that the Police Psychology Unit FTE increase will need to be 11 FTE positions.**
13. **Implement an integrated electronic client management system to enhance service delivery and reduce the risk of not responding appropriately to client service needs.**
14. **Amend the Victoria Police Act to include suitably trained psychologists to meet the demand for psychological fitness for duty assessments.**
15. **Medical Advisory Unit and Police Psychology Unit should be co-located under the same Division of the Human Resource Department.**
16. **Establish a sessional Psychiatrist position and a 0.5 Full Time Equivalent Clinical Psychology position to build in-house mental health specialist assessment and advisory capability. The placement of these positions should be considered when determining the service delivery model as part of the VicPol Mental Health Strategy.**
17. **An appropriate and minimal level of professional and peer supervision is essential (and should be quarantined from funding cuts) to maintain service quality and protect internal health service providers against the psychological safety risk of vicarious trauma. Police Psychology Unit can provide indicated supervision to Welfare and Peer Support Officers.**
18. **VicPol and The Police Association should renew efforts to work collaboratively on progressing a mental health and wellbeing agenda.**

### What would success look like?

**Overall reduction in mental health and suicide risk as indicated by relevant measures (e.g., lost time injuries, absenteeism, completed suicide rates etc.) in 24 months and onwards.**

# Chapter 7: Employee Lifecycle Health Management

***Key findings:***

- *Considering the overall organisational risk profile, it is now appropriate for Victoria Police to progress towards a more holistic co-ordinated employee lifecycle health and mental health management approach.*
- *Resilience, physical health education and mental health literacy content needs to be refreshed, upgraded and re-positioned as foundational (self-management) skills on the same level as any and all operational skills training content. To reinforce this, the content must also become examinable.*
- *Opportunities for family engagement at the front end, and support of partners and families across the employee lifecycle need to be increased.*
- *There was strong support from numerous stakeholders and interviewees to introduce regular mental health screenings for all employees. However, the Review Team concluded that any such blanket initiative would be inefficient and that the same funds could be much better expended to more substantively reduce mental health risk.*
- *A future VicPol wellbeing monitoring regime should be calibrated in a manner consistent with the organisational mental health risk profile and hence safe-t-net must have a central role.*
- *Early intervention initiatives, such as the current Trauma Group Pilot Program recently implemented by Police Psychology, should be expanded and further resourced.*
- *Police suicide rates can be significantly reduced – and this particularly depends on implementation of the organisation-wide mental health literacy and leadership uplift programs discussed in earlier chapters. These two initiatives will substantially assist in validating early help seeking.*
- *When someone is injured, there can be multiple contacts from a range of workplace personnel, the insurer and internal health services - that can be confusing and add to distress. Hence, a process whereby all contacts are funnelled through one key co-ordinating point, e.g., via a Welfare Officer and/or Injury Management Consultant who assume a primary case management role – should be piloted (note that it is also recognised that some contacts are necessitated by statutory requirements).*
- *When an employee is off work, the return to work evidence-base indicates that perceived support from, and regular communication with, local leadership is important and improves return to work outcomes*[23] *.*
- *Current return to work programs, particularly for psychological injury (or mental injury) claims are often poorly supported in the workplace. Lack of workplace support has been identified as a key factor in increasing the risk of poor outcomes.*
- *Moreover, lack of accountability for return to work outcomes contributes to overall compensation premium increases. Poor return to work outcomes have both direct costs to the organisation in terms of lost time, medical expenses and premium costs; as well as indirect costs in terms of reduced morale and engagement and lower productivity. These indirect costs can be up to four times higher than direct costs.*
- *The workers' compensation system can be challenging – and difficulties are even more pronounced where some claims are driven more by industrial agendas than substantive mental health issues.*
- *Most trauma-related clinical presentations can be managed on an outpatient basis. The current, often poor quality, clinical treatment received by police and other emergency service employees warrants the establishment of a state-wide specialist mental health service provider network.*
- *The retired peer support network should be appropriately funded and all retiring members undergo a mental health screening assessment, and where there is a significant work-related contribution, an appropriate treatment plan be devised, and funded by Victoria Police.*

23 The assumption here is that local leadership is not implicated in any 'bullying' issues. If this is the case, then regular contact is still important, but this would need to occur from someone at least once removed.

The combination of: (a) relatively higher exposure to potentially traumatic incidents; (b) the potential for cumulative impact of incident exposure; (c) the interactions with workplace and personal factors; and (d) the overall current mental health and suicide risk profile – warrant progression towards a more comprehensive employee lifecycle health management approach in Victoria Police. Such an approach coordinates health promotion, risk management, family engagement and health interventions according to the employee lifecycle from recruitment through to transition out of the service and retirement.

Victoria Police has already taken several positive steps in this direction, including development of a comprehensive occupational health, safety and wellbeing strategy (i.e., Zero Harm), comprising a new innovative safe-t-net wellbeing management system, and developing various health and safety initiatives that progressively accentuate the psychological health and safety of employees; and sponsoring innovative research projects from Deakin University researchers in suicide prevention and the Creating Healthy Workplaces project.

In Australia, the Australian Defence Force (ADF) introduced in 2008 nine 'Life cycle' initiatives variously directed towards addressing mental health issues that could arise from recruitment through to transition back into civilian life, and has continued to develop its employee lifecycle approach to health and mental health management since that time. The North American National Institute of Occupational Health and Safety (2012)[24] has promoted the notion of 'Total Worker Health' that seeks to integrate occupational health and safety risk management, health promotion, and health surveillance. Comcare is currently conducting a project around introducing the Total Worker Health notion to Australian employers.

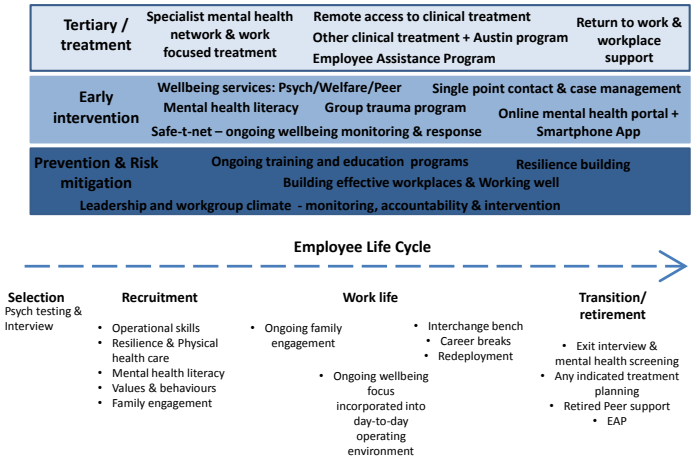


Figure 2: Employee Lifecycle model

## 7.1 Selection, induction and initial training

*"Like every other frontline member, I have had my share of traumatic incidents, but I believe I developed pretty good coping skills. Unfortunately, these coping skills involve me shutting down and withdrawing from everyone. I've lost a lot of friends over the years but that's the price I've paid." (Leading Senior Constable)*

The Review Team concluded that it is essential that resilience-building, mental health literacy and physical health education content be re-positioned as foundational knowledge and skills in recruit training, on the same level as all operational skills training. The Review Team noted that the ADF positions resilience and related content around the 'foundational strength' of 'mental fitness' and considers this to be on the same level as operational skills training. To that end, this content in recruitment training should become examinable. The impact of the current resilience content is diluted because it is not examinable.

*"It was interesting but not examinable so I put it aside and forgot about it because I had to concentrate on passing." (Leading Senior Constable)*

24 AL Schill et. al., (2012) The NIOSH Total Worker Health Program: An Overview. Journal of Occupational & Environmental Medicine, December 2013 - Volume 55

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The Review Team further concluded that the current Academy recruit resilience content should be refreshed and augmented, and the placement of sessions in the curriculum be reviewed to ensure optimal placement.

*"Relentless shift work is a frontline reality. It won't change." (Sergeant)*

*"I actively push Gilmartin and sent 15 of my team to the recent lecture." (VicPol member, 40 years)*

*"Not all staff can have a long career. The jobs we need most people in are the ones they want to get away from." (Senior Sergeant)*

The Review Team noted the strong resonance with members of the health and self-management advice offered by US behavioural scientist, Dr Kevin Gilmartin. He recently delivered sessions in Victoria during March 2016 (sponsored by The Police Association) that were attended by thousands of members and their partners. Amongst other issues, Dr Gilmartin (2002)[25] describes the potentially detrimental impact that shift work and increased vigilance in operational situations that can become over-generalised (i.e., to the extent that it becomes difficult to switch off from), has on the physical and mental health of police officers.

In interviews conducted by the Review Team, one question that was posed, particularly with long serving members, was about what helped them to personally cope with police work and maintain their wellbeing. The responses coalesced around some key themes including maintaining a social network outside of 'the job', maintaining a regular exercise regime, and active engagement in local community-based involvements.

*"I have networks in police but my best friends are my school friends and I'm busy being a parent, being on school committees and netball clubs." (VicPol member, 22 years)*

*"Exercise and contact with family and friends." (VicPol member, 27 years)*

*"It's important to exercise and I suggest and encourage members to go for a run or a swim." (VicPol member, 32 years)*

*"You have to work hard to maintain your outside friendships." (VicPol member, 37 years)*

As indicated above, the Review Team recommends that content on lifestyle and physical health management be included in recruit training. Over the course of the employee lifecycle, the new online platform and mobile phone Application will assist in providing ongoing relevant information.

## 7.2 Family engagement

*"He was off work and we needed help but didn't know where to get it." (Partner)*

*"He gave the job the best he had – we got the rest." (Wife)*

*"Can you have a website where the family can get some help?" (Wife)*

*"We are targeting the wrong people. We need to target family and friends-right from the first day in the Academy - and tell them how it will be. And then follow through with this. They are and will be always the first port of call." (VicPol member, 30 years)*

*"Marrying or being in a relationship with a police officer means you are signing a certificate for being a single parent. You need the energy to do all the chores, help with your children's lessons, and to share and care as for two parents. As a police officer they come home late, are on a quick shift changeover and in some cases never come home at all. You need the strength to wipe away your partner's tears, to reach out to them when needed, to hug and hold them, to care, to listen and to try to understand the traumatic events that have occurred on their last shift or previous shifts which they are now ready to talk about. We also need to wash their clothes for the next shift because someone has bled, vomited, died or a combination of all three on their uniform." (Wife)*

25 KM Gilmartin (2002), Emotional Survival for Law Enforcement, ES Press

Interviews and submissions received from partners and family members indicated a degree of frustration and not knowing where to turn for support or guidance when they became aware of changes and warning signs, or experienced more significant domestic issues including the effects of excessive irritability, extreme withdrawal, and even physical aggression. Moreover, partners spoke of wishing they were more alert to early warning signs and then had avenues to turn to for support.

The Review Team had contact with some partners whose domestic situation had even progressed towards family violence occurring – but they still felt very reluctant to seek help, mainly because of concerns that it might adversely impact on the employment of their partner.

Currently there is a family meeting held during initial Academy training. Beyond this, at present, there are negligible further options for ongoing partner/family engagement. The Review Team concluded that increased family engagement is critical and is very important for improving overall mental health and wellbeing outcomes. There is no current structure to facilitate ongoing contact, support, or seeking appropriate help when partners/family members perceive that their partner may be struggling with a work-related mental health issue. A VPS member related that he has a wife with a mental health illness and the *"Mental Health First Aid course gave me the tools to work through behaviours and provided me with an overview about what to expect, what's available."*

The Review Team also interviewed several individuals who were in effect 'case managers' of their partners who were either on WorkCover or retired but who were struggling to manage their on-going mental health illnesses. One commented how after her husband was wounded she had to *"fight for every dollar"*. Another retired member (22 years) who is presently the carer for his member wife, who has been diagnosed with PTSD, related "*she is too stressed to do the paperwork."*

Another wife who commented: *"It's pretty full on with managing my husband's situation including constant trips to Melbourne for psychology visits and there is always paperwork."*

The Review Team recommends that the initial family engagement be expanded to include an offer of attendance at various health education and mental health literacy sessions during recruit training. Again, the Review Team notes the resonance with partners and family members that was apparent in the recent sessions delivered by Dr Gilmartin in his visit to Victoria.

In the wider health literature, partners and family members are recognised as having a role in early detection of mental health problems and serving as 'therapeutic allies', i.e., reinforcing the practice of various strategies and techniques prescribed by health service providers. VicPol recognises the importance of family engagement and components of the online platform currently under development will serve a vital role in enabling ongoing family engagement through ready online access to relevant mental health information, accessing confidential advice and information on appropriate avenues for help seeking.

We again here make the point that, if a personal situation has progressed to the point of family violence occurring, then there may well be significant consequences for that employee's ongoing employment. The whole point here is that it is possible to intervene earlier and address issues before they progress to this point. Hence, with an increased early intervention focus - that should occur in response to implementing the Review Team's recommendations – there will be less likely to be detrimental consequences.

The Review Team spoke with a not-for-profit group, *Alongside*, which is currently providing services with Western Australian (WA) Police and soon with Northern Territory Police. The group originated from the lived experience of partners with their other partner working in a first responder organisation and experiencing mental health issues.

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It is focused on providing support services for partners. With WA Police, it provides a series of six education sessions during the initial training regime. Content is focused on health information (consistent with the Dr Gilmartin message), awareness of early warning signs and other mental health literacy content. It also runs ongoing social events and establishes regularly meeting 'reach out groups' for partners of police officers. These groups are akin to peer support groups and have a structure and guidelines around not straying into any counselling or management of mental health issues. The Review Team recommends that Victoria Police further explore this type of initiative to address the identified need for increased family engagement.

The Review Team also noted the need to consider family engagement with Protective Service Officers (PSOs). Given the unsociable hours for PSOs and the impacts on their families, being a partner can be very isolating. In addition, many are from different cultural backgrounds and may not have their usual support networks accessible locally. Further, they may not be connected to local cultural communities, and for some, language may be a barrier.

Hence, the Review Team noted and fully supports a preliminary proposal already under development to design and implement a family support network for PSOs. This should be further developed and receive appropriate organisational support. We understand that consideration is being given to launching a family day type initiative, for example, a family picnic that PSOs and their families could attend where there might be some input from VicPol, information stalls or show bags to give families that include information on the various VicPol support services and possibly with various community representatives to attend that reflect common cultural backgrounds. The goal would be to facilitate culturally similar families and partners socially connecting with others to form their own networks and social supports. Subsequently, regular meetings or events could be established to develop a relatively self-sustaining group, but with perhaps support from PSO's who are peers for instance.

## 7.3 Wellbeing monitoring, mental health screening and safe-t-net

The Review Team found strong support from a wide range of interviewees and stakeholders, for introducing regular mental health screenings for all Victoria Police employees. The Review Team noted that in 2011, the Police Psychology Unit had wound back this type of program, due to very uncertain evidence that substantive reductions in mental health risk were actually being achieved. Currently, regular mental health screening is only conducted for a number of specialist groups.

Whilst popular, the Review Team concluded that the substantive evidence-base supporting all employee mental health screening assessments is negligible and that this type of blanket initiative is very costly. Accordingly, the Review Team carefully considered where the greatest impact could be achieved to reduce organisational mental health risk.

In deliberating on this issue the Review Team took into account a number of considerations and explored several options. A primary consideration was the current implementation of the safe-t-net system, as well as the substantial commitment already undertaken and the potential to reduce mental health risk. Further, the Review Team was cognisant of the principle that any mental health screening regime should be calibrated against the organisational mental health risk profile and managers should not be absolved unwittingly from their people leadership responsibilities around the welfare of employees.

Many options were explored, including embedding a mental health screen with a regular physical health check-up. However, the Review Team became convinced that the latter is not indicated due to the estimated very large volume of individuals who would pass each time and would not be cost effective. From a population health perspective, the understanding of medical risk factors is currently more evolved than the understanding of mental health risk factors, and hence a more targeted physical health assessment program is likely to be indicated according to known age cohort

and other medical risk profiles. In relation to this, the Review Team also noted that there is a current VicPol review of physical fitness standards underway.

*Overall, the Review Team did not find sufficient evidence to warrant recommending moving to annual blanket mental health screenings for all employees. It was concluded that such an initiative would be extremely costly and inefficient. Rather, the Review Team concluded that wellbeing checks should be anchored around the mental health risk profile, (i.e., as particularly indicated by the safe-t-net system).*

The Review Team identified four key forms of wellbeing monitoring that should all be recognised and incorporated in the VicPol Mental Health Strategy:

a. A formal wellbeing check (i.e., mental health screening conducted by a psychologist);

b. An informal wellbeing check (i.e., the welfare conversation conducted by a manager);

c. A self-managed online wellbeing assessment (this has already been contemplated to include with the new online mental health portal and the Review Team support this); and

d. An informal co-worker wellbeing check: casual 'care and concern' type conversation initiated by a colleague in response to identified signs that a co-worker is behaving differently than usual.

The Review Team recommends that a formal wellbeing check (mental health screening with a psychologist) should be triggered by:

a. The local manager, as a consequence of any concern arising out of their informal wellbeing check (i.e., a welfare conversation triggered by safe-t-net), or otherwise by identification of any early warning signs in the workplace; and

b. Directly triggered via safe-t-net in response to sequential high ratings (e.g., for probably two or more incidents).

The Review Team recommends that extant formal wellbeing check regimes with high risk groups be continued.

The safe-t-net system triggers a need for a wellbeing check type conversation between the manager and employee, following registration of an operational incident. Included in the conversation is rating the psychological impact of the incident. Safe-t-net also has the advantage of being able to incorporate a wide breadth of potential triggers or stressors. Managers will be able to recognise that certain members may have other factors that could impact on their professional lives. For example, many female members are in the "sandwich generation". That is, at age 50 to 60 years, they have responsibilities for teenagers, young adult children and grandchildren, but also their ageing parents. While male members will also have family pressures, the care factor is likely to impact more on females.

Another example where it may assist is with post-natal depression. Several female interviewees and one male interviewee noted that post-natal depression had been experienced. Perhaps, more tellingly in most instances, reportedly no effort was made by supervisors to inquire as to how 'things were going', with one female commenting: *"I could have been at risk to myself or to others when I returned to work after my maternity leave and no one would have known".*

The Review Team concluded that safe-t-net has huge potential for improving mental health and wellbeing outcomes across Victoria Police (challenges with achieving the full potential of the safe-t-net system were discussed in Chapter 5). This is currently being implemented. Also noted in Chapter 5, the Review Team has concluded that Victoria Police has significantly under-estimated the indicated culture change and leadership capability requirements that are needed to make this program work effectively. Accordingly, there is an urgent need for systematic training and development of Sergeants, Senior Sergeants and Inspectors (this is discussed in Chapter 5).

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We note that one organisational risk is that the safe-t-net system could become a 'tick and flick' exercise for disinterested managers, or managers with poor people management skills. We further note that individuals have the option of having the conversation with someone other than their immediate manager and this can be monitored centrally. Hence, where this occurs, this should also be considered to be a flag for possible poor people skills or work relationship problems and warrants intervention.

One Review Team member likened this intervention to a 'HR SWAT Team' approach. The Review Team noted that it is being considered, for example, that the Performance and Development Unit could monitor these types of safe-t-net flags. Wherever this monitoring team is housed, it must be adequately resourced, preferably including an organisational psychologist from Police Psychology and a HR practitioner specialising in leadership development. This team should provide individual coaching and development support to individual managers that are flagged. The intervention could be triggered, for example, when there are three or more requests involving two or more members, to have a conversation with someone other than their immediate manager. Such flags would, of course, need to be further calibrated based on experience with the system.

Further, consideration will also need to be given to what limits are placed around reasonable development support for a struggling leader. It is the experience of other organisations that increasing the accountabilities around the management of people issues does identify some individual managers who are actually unsuited to being in a people leadership role. Such leaders directly generate psychological health and safety risk and thus this issue will need to be addressed.

We note that Police Psychology already currently reviews incidents, according to the evidence-based Psychological First Aid protocol and attends incidents as warranted by their assessment. This is appropriate and consistent with good practice. This protocol does place an emphasis on the role of local support and initially not over-medicalising a situation, and monitoring. Further mental health screening, and potentially accessing treatment, is triggered as a consequence of this extant monitoring regime[26] .

As noted above, the manager conversation should also be triggered by identification of early warning signs in the workplace. It does not involve the manager becoming a quasi-counsellor or diagnostician; it is undertaken within the bounds of being a supportive people leader. As indicated, a manager may potentially then trigger a formal wellbeing check with a psychologist.

The Review Team also supports the development of an online self-assessment option to provide a further avenue for conducting a wellbeing check. This is already underway with the new online platform development. One form of mental health stigma not discussed in Chapters 4 and 5 is 'self-stigma'. This is where an individual is reluctant to discuss symptoms they may be experiencing out of a sense of social embarrassment or shame, even with their own treating GP. Being able to undertake an anonymous check can increase the prospect for a person to subsequently break through this type of stigma and eventually seek help.

It is important to finally note that a colleague may well potentially also conduct this type of informal welfare conversation with a co-worker. One effect of an organisation-wide mental health literacy program is to foster more of a shared sense of responsibility and to empower team members to 'look out for one another'. This is an informal collegial wellbeing check and could be characterised as a straightforward 'care and concern' conversation that is directed towards encouraging the colleague to seek assistance.

26 As an aside, the Review Team noted that there is sometimes pushback from managers when Police Psychology do not attend a particular incident. The Review Team concluded that this should lessen as a function of increasing organisational mental health literacy and better appreciation of the critical role of local workplace support in maintaining morale and thereby facilitating individual member naturalistic coping responses. The strongest pushback appears to come from managers who do not view the welfare of their staff as part of their responsibility as a people leader.

It is anticipated that the combined impact of:

a. Organisation-wide mandatory mental health literacy training;

b. The 'leadership uplift'/leadership culture change program; and

c. Safe-t-net

- will significantly increase the number of formal mental health screenings that need to be undertaken. Hence, this will also require an increase in Police Psychology Unit FTE positions.

*Overall, the Review Team concluded that genuine and measurable improvements in mental health, wellbeing and suicide prevention outcomes are achievable through adequately funding and resourcing these three key initiatives, and that this will yield much more impact per dollar expended, than would be achieved via funding of any blanket annual mental health screening regime for all employees.*

## 7.4 Timely and appropriate intervention

*"My husband pushed me to counselling when he started noticing at home that I was changing." (VicPol member, 16 years)*

*"I told a member to talk to someone. He didn't want to. I kept at him. He thanked me later." (VicPol member, 22 years)*

Early help seeking and accessing appropriate support and treatment is effective early intervention. As the organisation-wide mental health literacy strategy progresses, and individuals begin to believe that wellbeing issues are validated and progressively integrated into the DNA of the day-to-day way in which groups and teams operate, this will be achieved.

The recent early intervention Trauma Group Pilot Program (12 once weekly sessions) conducted by the Police Psychology Unit aimed to engage individuals with early (sub-clinical) symptoms of trauma-related mental health problems. Phoenix (the national PTSD Centre) helped with the design of the program and is assisting with its evaluation.

The Review Team considers that this program is a fine example of the type of early intervention program that should be supported and expanded across Victoria Police. Research indicates that this type of program – developed on the evidence-based Psychological Skills for Recovery (PSR) model – can prevent the development of full-blown PTSD and associated likely higher levels of work incapacity. In other words, early participation in this type of program holds out the potential of assisting employees regain full operational functioning status.

The program has concluded and early results are very encouraging. The program will be further evaluated to assess enduring effects on the mental health of participants (e.g., at six and 12 months post program). The program also features a family engagement component that has received positive feedback.

Further, the new online platform currently being developed should also significantly enhance the early intervention focus in Victoria Police. This platform will contain various self-assessment and mood monitoring tools, physical health and mental health information, and details regarding further avenues for help seeking and treatment.

The Review Team also noted a pilot program, Separating with Support and Safety – an early intervention program developed by one of the Psychology Unit staff - that is about to be implemented. This program is aimed at members going through separation/divorce/relationship breakdown and involves provision of information about relevant resources and avenues for accessing support, and advice. The Review Team understands that this program will be piloted with Peer Support Officers – because of their key frontline contact role with members. The Review Team strongly supports this innovative early intervention initiative.

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## 7.5 Suicide prevention

*"I was eight years old when my father killed himself." (Daughter of member who died by suicide)*

*"You've just got to learn to live with it and let it go." (Advice to a widow from a senior police officer, a few weeks after a police funeral and memorial service for her husband)*

There is limited police specific suicide prevention research – most research in this field has been conducted with military populations. The one major study identified in our rapid literature search evaluated a Canadian Police comprehensive suicide prevention program (Mishara and Martin, 2012)[27] .

The Montreal police service implemented a comprehensive suicide prevention program, *Together for Life*, from 2000, that included a half day mandatory training program for all units, with content on the nature of suicide, identification of suicide risk, and how to help a colleague in difficulty. A telephone helpline was established with options for callers to choose from four areas: traumatic work events, lesbian, gay, bisexual, trans and/or intersex issues, substance misuse (alcoholism) and gambling, and marital and relationship problems. The helpline was staffed by volunteer police trained in suicide prevention. There was also a one day supervisor and union representative training session conducted by psychologists focused on enhancing capacity to identify at-risk employees and how to provide support. The program was supplemented by a publicity campaign with published articles in internal newsletters, posters and brochures. The program was evaluated over 12 years and the suicide rate of Montreal police officers reduced by 79 percent over this time (from 30.5 per 100,000 to 6.4 per 100,000). By comparison, other Quebec police services that did not implement the program showed no reduction in suicide rates, and in fact showed slight increases.

Consistent with the broader suicide prevention literature, the Montreal study suggests that *police suicide rates can be very significantly reduced*. The Review Team anticipates that the recommended comprehensive organisation-wide mental health literacy program will contribute towards reducing suicide rates in Victoria Police.

We have earlier noted that Victoria Police is sponsoring important research being conducted by Deakin University team, the Suicide Evaluation for the Prevention of Suicide (StEPS) program; that is looking at interactions between individuals and systems including disciplinary and workers compensation etc. The Review Team received an update from the researchers but the project is still in its early stages and hence no results were available at time of preparing this report.

Without pre-empting the outcomes of the Deakin research, the Review Team concluded that suicide prevention content (i.e., educational information, warning signs and how to provide support, tailored for all employees and managers), should be a specific component incorporated into the comprehensive mental health literacy program recommended in Chapter 5.

The capacity of Police Psychology and Welfare to monitor and provide an ongoing case management service for at-risk employees must be adequately resourced to provide this service. The establishment of an ongoing case management and monitoring relationship can have a quasi-therapeutic effect and reduce suicide risk.

The Review Team also noted that there is a national suicide prevention framework[28] and that the Victorian State government is currently in the process of finalising a series of suicide prevention recommendations. The Review Team recommends that the VicPol Mental Health Strategy should be aligned with the underlying principles of the national framework and be consistent with Victorian government recommendations.

27 BL Mishara & N Martin (2012), Effects of a comprehensive police suicide prevention program. Crisis, Jan 1:33(3)

28 National Suicide Prevention Strategy (2014) Australian Government, Department of Health

Recently there have been changes to the guidelines for reporting on and publicly discussing suicide and completed suicides (Australian Government Mindframe national media initiative). Traditionally, the dominant view was that reporting should be avoided due to the risk of triggering copycat suicides. By contrast, the contemporary approach is basically to report straightforwardly, without sensationalising and not describing the means utilised. Further, to indicate the devastating impact on family, friends and colleagues, and finally to provide information about avenues for help and support.

The Review Team noted comments from stakeholders (including Legacy), partners and colleagues suggesting that Victoria Police communications in this area (e.g., through The Gazette) often resort to euphemisms, e.g., 'died suddenly' in reporting suicides. This is a fraught area. However, the strong recommendation from all interviewees who raised this matter, and Legacy, was to align all Victoria Police communication and reporting with contemporary practice, as indicated above.

The Review Team agrees and further recommends that the Police Psychology Unit could be consulted to assist in fine-tuning any such communications as and when indicated.

## 7.6 Initial contact when someone is injured

From an organisational perspective, when someone is injured, they can experience multiple contacts from a range of different stakeholders in the days following: this can include an injury management consultant, police medical officer, police welfare, police psychology, the workers' compensation insurer (if a claim is submitted), various local managers and The Police Association etc.

Figure 3: Possible contacts with the employee

Such multiple contacts can potentially overwhelm the individual and generate confusion and uncertainty, adding to their distress. Advice is provided from various stakeholders that may not always be co-ordinated. There may be various forms to complete and, if the injury is work related, then potentially navigating through the workers' compensation system.

Feedback from injured workers in various jurisdictions, and reviews undertaken by a number of organisations, suggests that co-ordinating contacts around an ongoing primary single point of contact helps to reduce distress and facilitate recovery. Thus, the employee experiences an initial contact that establishes a case management relationship; and the case manager also helps to coordinate, filter and initiate further indicated contacts. This case manager has responsibility for drawing up a management plan. The plan can contain mandatory indicated contact sections regarding various internal resources.

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The approach of re-configuring contacts around a single point of ongoing primary contact was considered by the Review Team to be worth further investigating and trialling. Here we note that VicPol Wellbeing staff have already invested considerable effort in addressing this issue and have concluded that the prospects for a single point of contact are potentially viable and should be piloted. Thus, the Review Team endorses their conclusion and recommends that the single point contact model devised by Wellbeing staff continue to be piloted. The model centres on a welfare officer, partnered with an injury management consultant being responsible for the first contact. One of these two, depending on the injury profile, thereafter becomes the subsequent primary contact and case manager and prepares a management plan. This party then establishes an ongoing case management relationship, with regular contacts made to the injured employee, the frequency of which would be dictated by the injury profile (i.e., if the person has a high level of emotional distress and there are particular complications that need to be urgently addressed, then the contact would be more frequent). Note that some statutory requirements for contact also need to be factored in, particularly if the case is compensable.

If there are any mental health issues involved, then the Police Psychology Unit should be consulted for advice and input into the management plan. This should be mandatory. This approach should facilitate developing a more comprehensive and integrated understanding of the injured person's situation, and their treatment needs and other relevant issues - instead of information being fragmented and residing with multiple stakeholders who do not always co-ordinate or effectively share information. The current fragmented nature of where work-related and health information is retained across multiple parties, mitigates against the development of effective comprehensive management plans and must be addressed. The Review Team also noted a request received to ensure VPS employees are included in considerations of frontline care and also counselling. For example, a member of the Media Unit noted that this unit is:

> *"The conduit between the police and the journalists and it would be good if we were also offered support following a trauma which we get to know all about - an email would be a good start."*

The Review Team understands that the safe-t-net system will apply as equally to all VPS as sworn employees. This system, as discussed above, triggers a welfare discussion with a manager (informal wellbeing check), and once a certain level is reached on frequency and intensity indicators will trigger, as the Review Team has recommended, a formal wellbeing check (mental health screening with a psychologist).

The Review Team has earlier noted that police welfare positions should be increased. Accordingly, the move towards implementing the primary single point of contact case management model is estimated to require the appointment of an additional six FTE welfare officers. This would, overall, equate to having an additional welfare officer for each of the four Regions, and one for Transit and Public Safety Command and one for other departments. Social workers and other welfare qualified VPS staff could also be considered for these roles. The Review Team recommends that this model be trialled for 12 months and then reviewed.

## 7.7 Management of work-related injury and return to work

The current workers' compensation premium for Victoria Police is in the vicinity of $50millon. This is expected to continue to increase. Our first comment in relation to this is that the Review Team was struck by the lack of local manager accountability in relation to return to work programs. As part of the leadership culture change, it would be advisable for VicPol to endorse and support the view that there is an expectation that members will return to work following an episode or repeated episodes of mental illness. This could also be reinforced by KPIs for supervisors and senior managers. It will also be necessary to, as one retired member (37 years) stated:

*"Return to work is a therapy; it is not a performance issue."*

The Review Team encountered a number of managers who seemed not only disinterested, but also actively disengaged from the return to work process.

*"There's nothing wrong with him, he's not interested in working. I'd prefer to leave him at home rather than bring him back. I'm going to wait for the 104 weeks to run out." (Senior Sergeant)*

*"When I met with my Inspector and the WorkCover person, the Inspector spent the meeting drawing on his coffee cup and then said 'Perhaps you should find another job'. I thought we were going to fix the issue. The WorkCover person rang the next day and apologised." (VicPol member, 28 years)*

This was variable and there were other managers who were engaged and achieving positive return to work outcomes. Overall, the accountability issue needs to be urgently addressed. The experience of other organisations is that premiums do reduce[29] when there is increased local accountability for return to work processes. One issue raised is that this can be disproportionate where there may be a clinically severe case that is unusually costly. This can be addressed and allowed for in development of an appropriate KPI for middle level managers[30] .

Another key issue identified by the Review Team here harks back to our findings in relation to mental health stigma discussed in Chapters 4 and 5. Above and beyond clinical factors and clinical treatment, perceptions of workplace support have been identified in the return to work, as well as the PTSD, research literatures as a critical determinant of successful return to work outcomes.

*"I've been back on a return to work program after suffering PTSD for some eight months now, and no one – not anyone I work with or any manager has asked me, 'how are you going', 'how are you travelling?" (VicPol member, 18 years)*

*"It would be really good if someone at the station level would help facilitate the return to work on the first day and make it a point to meet and greet and even to have a cup of coffee prior to the return. I forced myself to do it and if someone had met me, the experience would have been shared." (VicPol member, 10 years)*

One of our Review Team members recently assisted Safe Work Australia on a review of employer responses to the return to work of injured workers[31] . The most recent review (not yet published) included a focus on the role of the workplace. The key findings reinforce the point made above that perceptions of workplace support, particularly from local management, can facilitate, delay or even derail return to work.

Irrespective of how much professional support has been provided, if the individual does not perceive that local management has been supportive, they will consider themselves overall not to have been supported by VicPol.

*"It is not a weakness to seek help. The stigma that exists is police stigma. If a police member admitted to having mental health issues, there is a belief that this would erode confidence in police, but this is narrow minded and pig ignorant." (Vic Pol member, 27 years)*

The Review Team would expect that as the general level of mental health literacy and people-focused leadership capability increases that this problem will improve. But there is also a need for increased accountability, as indicated above.

29 The Review Team does recognise that the inputs to premium calculation are complex and also include remuneration considerations affected by the number of FTE positions and EBA arrangements. The point here is that improved return to work outcomes do contribute to premium reduction and substantively reduce the toll of human misery along the way. The key here is workplace support, particularly as demonstrated by local managers.

30 The challenge of addressing liberal GP certification practices is also acknowledged here and is recognised by the Review Team in our recommendation for establishing a specialist mental health services provider network.

31 The review encompassed analysis of data from a cross-jurisdictional telephone-based survey of injured worker experience of progressing through workers compensation processes, treatment, return to work and employer responses.

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## 7.8 Interchange bench

One of the Review Team members coined the notion of the 'interchange bench' to describe the need for non-operational roles as an interim measure to assist with return to work. Best practice return to work involves engagement with employment as early as possible, while treatment continues concurrently, and with alternative duties if indicated. Where such options are available, return to work outcomes are improved.

> *"So many have the wobbles and are calling out for help. Resting capacity is limited – they need to get some fresh air." (Assistant Commissioner)*

> *"I put my hand up and took a short break. It was the best thing I could have ever done." (Leading Senior Constable)*

> *"There aren't that many options for return to work." (Leading Senior Constable)*

There are times when operational members are in need of 'time on the bench'. These may present in either a return to work scenario or as an early intervention step following identification of mental health related symptoms. The National Health and Medical Research Council endorsed PTSD Guidelines (Phoenix, 2013) note,

> *"It is rarely helpful to remove the person from the work situation altogether. Such an approach creates problems in terms of daily activity scheduling and makes rehabilitation and return to work harder. Rather, an opportunity to perform a different (non-frontline) role at work provides access to organisational and collegiate support, daily structure, and a sense of self-esteem that can greatly facilitate recovery." (p.151)*

The Review Team noted that more and more non-operational roles have been abolished. The 2011 Building Operational Capability and Capacity (BOCC) process converted 150 permanent sworn positions in administrative, corporate and non-operational roles to the frontline. Apart from increasing frontline capacity, this process aimed to reduce the number of staff performing non-core roles for, in some cases, many years.

Positions similar to those that today remain filled on a permanent basis, effectively reduce the capacity for frontline staff to be temporarily placed in support positions, for health-related and proactive early intervention or recovery reasons. The Review Team formed the view that capacity exists for the future use of these positions in a more strategic, beneficial and flexible manner.

Submissions received and interviews conducted in this review have highlighted the need for temporary placements 'on the bench' to be available when staff are dealing with wellbeing challenges. It is acknowledged that the demand for frontline police is paramount, however, a shift in perspective, where temporary prevention and rehabilitation placements are considered routine, supports the mental health improvements identified in this review. Such positions may be identified in regional or departmental settings.

Creating non-operational positions for the sake of giving operational members 'time on the bench' is a real risk unless strict time in position rules are applied. It is not proposed or intended for members to occupy and never return to frontline duty, as this would defeat the intent of the 'interchange bench' concept.

Hence, these temporary placements should be tightly managed with detailed plans. By virtue of there being a mental health issue involved, this does not entail that the approach should be 'hands off' and allow the individual to determine the duration of their break[32] .

Individuals with mental health problems progress better, and have better return to work outcomes, where there is clarity around parameters, clear expectations and timeframes.

Where this is not the case, then the likelihood increases of medical indications and personal

32 This also applies to treaters who may lack relevant specialist mental health expertise, and hence be overly generous with total incapacity certification. One example of addressing this is the WorkSafe Early GP Contact Program where GPs are contacted to discuss whether their patient may have at least partial capacity and hence could engage in some modest re-engagement with work.

preferences becoming confounded.

> *"What's next – off line or return to duty? We can't create a dumping ground. Medical vs industrial – the trick is in the placement." (Superintendent)*

The Review Team further noted comments from numerous individuals suggesting that their return to work duties were not particularly 'suitable'.

> *"I was given a spot next to the photocopier on my own so that I wouldn't have to interact. I am a leper." (VicPol member, 17 years)*

> *"I was made a project officer, which is a paper clip counter and I was still sick. I felt like I'd been given the label 'if you can't stand the heat...'" (VicPol member, 27 years)*

The Review Team recommends that regional and departmental managers are assisted in enhancing the environment where locally established 'temporary' placements are used as needed as a standard option. Existing staff funding models may need to be reviewed as part of a broader expansion of flexible employment options under consideration as a result of this review and the VEOHRC report recommendations.

There were also positive accounts of supportive supervisors, for example:

> *"My supervisor was great and I can't complain at all. The only issue was a lack of consistency as there are always different managers." (VicPol member, 22 years)*

## 7.9 Workers compensation

At the tertiary end, the workers' compensation system can be daunting. It is widely reported as being challenging and often stressful. This is not unique to Victoria Police. WorkSafe undertakes regular reviews of worker satisfaction with the compensation process across all industry sectors and has identified a number of challenges.

WorkSafe funds the Institute for Safety, Compensation and Recovery Research (ISCRR) to conduct research on a range of issues including claims management and decision-making processes, with a view to improving how all workers negotiate their way through the system. The Review Team noted that, seemingly more so than in other industry sectors, the workers' compensation system for police often does not function in the manner intended, because it is diverted by industrial agendas.

The insurer has a thankless task. They must go through processes to establish that a claim should be accepted. Getting the balance right is challenging – there must be criteria that need to be assessed, as there are many examples from various other jurisdictions where lax criteria have fostered a range of inappropriate practices.

*The Review Team concluded that reducing the number of individuals who need to enter the workers' compensation scheme in the first place, through an increased focus on prevention and early intervention initiatives, is an over-riding priority. This is achievable for Victoria Police. The Review Team is confident that the implementation of our recommendations will lead to a reduction in the number of individuals that enter the workers' compensation system.*

The current Gallagher Bassett–Victoria Police triage approach was considered to be sound and consistent with good practice. The Review Team recommends that, as indicated, sessional specialist mental health input be accessed, as indicated, to advise Victoria Police and the insurer as part of the claims determination process. This is probably best sourced externally, to keep Police Psychology one step removed from any possible perception of supporting the insurer.

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Furthermore, either the Workers Compensation area or the Police Psychology Unit increase capability in occupational rehabilitation psychology to provide a type of consultation liaison input, to assist Injury Management Consultants managing compensable or non-compensable psychological injury cases.

The Review Team noted that Ambulance Victoria has recently put out an expression of interest request to a number of organisations in an attempt to expand potential employment options for paramedics who may be deemed permanently unfit to return to frontline paramedic duties, but could potentially utilise their skills in other settings. It is recommended that Victoria Police should also explore redeployment prospects with other organisations along similar lines. In other words, options for return to employment outside of VicPol are worthy of further investigation.

## 7.10 Clinical management and the treatment of PTSD

*"I was put in touch with an external service provider who referred me to a local psychologist. I had one session with this psychologist and walked out of there feeling worse than before I went in. She had no knowledge of police work and had obviously never dealt with police officers. I found myself explaining things like shifts, rank structures, transfer and upgrading. She had no idea about any of it. Furthermore, she seemed surprised (if not shocked) when I started to detail some of the more grisly aspects of my job, things that I discuss with my colleagues every day." (Leading Senior Constable)*

Particularly in relation to the treatment of PTSD, the Review Team noted some strong views that participation in the Austin Hospital PTSD program (or now also a similar program being offered by the Melbourne Clinic) is the only appropriate treatment. Indeed, the Review Team came across instances where many individuals were receiving no treatment at all over and above standard GP monitoring and care, and several individuals who had been sitting at home passively, waiting six or more months, to attend this program. In the opinion of the Review Team, this situation is intolerable. The longer engagement in treatment is delayed, and the longer an individual does not engage in any work, the greater the risk for worse long-term mental health and poor return to work outcomes (Consensus Statement on the Health Benefits of Work, 2015)[33].

PTSD treatment is one of the most strongly evidence-based and clear-cut mental health treatments available. We now have two sets of detailed treatment guidelines available: the National Health and Medical Research Council endorsed Phoenix Guidelines (2013) and the recently released expert consensus guidelines, *The Treatment of PTSD in Emergency Services Workers*[34] .

The Emergency Services PTSD Guidelines particularly help dispel the myth that hospital-based inpatient or day based treatment is the only appropriate treatment option. Most PTSD presentations can be treated on an outpatient basis. The primary indicated treatment is not medication but trauma focused cognitive-behaviour therapy. Hospital-based programs have a role, and are primarily indicated for the clinically most severe cases. More generally in relation to public hospital admissions, the Review Team noted some strong feedback:

*"One VicPol member tried to hang himself and he was sent to a public mental health ward with the very people that he's dealing with every day." (Mental health nurse)*

*"I was sent to the Austin Hospital (not the PTSD program) and I was verbally threatened by a Vietnam Vet who said he'd kill me while I slept." (VicPol member, 38 years)*

*"My wife was put into the mental health ward at a public hospital with ice addicts and others that she'd had previous dealings with. Why would they do that?" (Husband of VicPol member)*

33 Australian Faculty of Occupational and Environmental Medicine (2015) Consensus Statement on the Health Benefits of Work.
34 Black Dog Institute (2015)

WorkSafe Clinical Panel[35] reviews suggest that approximately 50 percent of injured frontline responders (and all injured workers suffering from PTSD) still do not gain access to the most appropriate treatments. Rather, they are likely to be medicated and managed by standard general medical practitioner care and monitoring, and/or see psychologists who are not experienced in delivering trauma-focused cognitive behaviour therapy – who instead, focus on inappropriate supportive counselling and other non-trauma focused interventions[36] . This type of treatment actually increases the risk for worse outcomes. Medication has a role, but it is a second line treatment indicated when levels of psychological distress are so severe as to interfere with functioning and engagement in the indicated frontline trauma focused psychological treatment. Moreover, the current Employee Assistance Program (EAP) for VicPol (as is typical of EAP providers) is not equipped to provide the type of more specialised psychological treatment that is often indicated.

It is also important to note that many members experience trauma type symptoms that do not meet criteria for a clinical diagnosis of Post-traumatic Stress Disorder. Hence, the Review Team notes again, the importance of initiatives such as the early intervention Trauma Pilot Program. Expanding this program and validating early help seeking, through the stigma reduction and culture change initiatives already outlined in this report, will help to reduce the number of individuals that end up being diagnosed with PTSD.

The Review Team formed the view that the Police Psychology Unit should continue to offer treatment to some members as indicated. This will also be enhanced by further building in-house specialist mental health capability, as recommended earlier.

The other issue identified by WorkSafe Clinical Panels are two biases exhibited by health professionals, particularly GPs and Psychologists. Firstly, by virtue of being an emergency service worker, the diagnosis of PTSD is more readily given (even where it is not actually clinically indicated).

Hence, in this sense, PTSD is over-diagnosed [37]. Secondly the PTSD diagnosis tends to be, ipso facto, automatically equated with total work incapacity even when this may not be objectively indicated. Many individuals with PTSD can remain at work, albeit often on temporary alternative duties. Ongoing certification for total incapacity increases the risk of a poorer return to work outcome.

WorkSafe Victoria has been conducting an Early GP Contact pilot program where Clinical Panel GPs, Clinical/Health Psychologists and Physiotherapists contact treaters to discuss incapacity certification. Early indications are that there is often confusion about certification and a lack of understanding that there can be partial capacity certification indicated: i.e., there are other options than certification of total incapacity or clearance without restrictions.

Because of this overall problematic state of affairs, the Review Team recommends that Victoria Police establish a network of specialist mental health professionals (Psychiatrists, Clinical Psychologists and, as indicated, other Psychologists with demonstrated advanced training in this field) who can treat Victoria Police employees on an outpatient basis.

35 The Clinical Panel consists of highly experienced Clinical and Health Psychologists and Psychiatrists who undertake peer to peer treater reviews to look at the appropriateness of the treatment being provided to injured workers across all industry sectors including emergency service workers, and whether the treatment is suitably return to work focused. Clinical Panels rely on the National Clinical Framework – as the treatment quality assurance framework reference. The Clinical Panel operates across WorkSafe and the Transport Accident Commission Victoria and conducts in excess of 900 secondary treatment reviews each year.

36 Cotton P (2014) Workplace psychological health and wellbeing: An overview of key trends. InPsych, December, Australian Psychological Society

37 The complexity here is that whilst PTSD is over-diagnosed by GPs and Psychologists, it is also under-recognised due to mental health stigma where genuine sufferers either do not recognise symptoms or avoid seeking help due to fear of detrimental consequences on their career prospects.

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This could be on the basis of service level agreements that include agreed timelines to access appointments, and three key criteria providers sign up to:

a. Agreeing to fully align their psychological and pharmacological treatments with the *Emergency Services PTSD Guidelines*;

b. Endorsing the Australian Health Benefits of Work Agenda; and

c. Agreeing to fully align their practice with the *WorkSafe Clinical Framework* (i.e., committing to delivering 'work focused' treatments).

These providers could be managed as part of the VicPol Employee Assistance Program Panel and receive early intervention referrals. The budget allocated for standard EAP sessions could apply. Additional sessions would be discretionary and contingent on VicPol review – as to whether further sessions would be funded by VicPol or via a Medicare Mental Health Plan. Further, VicPol could seek endorsement from WorkSafe to facilitate funding of compensable PTSD conditions.

Furthermore, members of the network could be utilised in a manner akin to a Clinical Panel function, to assist with contacting GPs to address certification issues and seek, where appropriate, partial clearances to re-engage with suitable employment as early as possible.

This 'trauma network' of specialist mental health service providers could also be utilised for undertaking rapid early clinical assessment of workers compensation claimants to provide accurate diagnosis and the development of an indicated treatment plan to ensure members are able to access appropriate treatment for the right clinical issue, at the earliest opportunity. This would also help facilitate progression of legitimate and accurate claims, thereby reducing the stress of the workers compensation system itself. It could also be applied pre-claim where there are indications of significant impairment due to mental health issues.

The role of work in contributing to positive mental health is still poorly recognised among treating health professionals. Re-engagement with suitable employment should be a core aspect of any clinical treatment provided. Based on workers compensation data, if a person is off work for six months then the chances of successfully returning to work are approximately 40 percent. If a person is off work for 12 months, then the prospect of successfully returning to work has diminished to less than 5 percent.

Some individuals do eventually become permanently and totally incapacitated for work as a result of their chronic mental health condition. However, a triage approach is indicated where work focused treatment is the norm and workers who cannot engage are triaged out.

Police and other first responders should be able to access high quality clinical care that gives them the best prospect for recovery and re-engagement with suitable employment. We still lose too many individuals, through 'iatrogenic' causes, due to a lack of access to clinically appropriate and work focused treatments.

The Review Team did not have a comparable level of information available to comment on the treatment of depression and substance misuse. The proposed prevalence study will likely provide relevant information that will assist in considering further fine-tuning of internal and any arrangements for accessing outpatient services.

## 7.11 Remote access to clinical treatment

Another issue that the Review Team considers appropriate to comment on is the issue of regional and remote access to indicated clinical treatment. There are many areas in Victoria with no ready access to Psychiatrists or Clinical Psychologists. There is no easy solution to this situation. One option being pursued in the broader health system is the use of secure video conference facilities and Skype-based-sessions to deliver treatment sessions.

These types of delivery modalities are being increasingly deployed in the distance treatment of mental health problems in rural and remote populations. There is also video conference technology increasingly available that can be readily accessed via any web browser.

The Review Team envisages that there may be cases where the particular presenting clinical profile, the lack of access to local suitable clinical service providers, and the costs involved in other ways of accessing suitable treatment – will warrant use of these online delivery modalities. Such cases could be reviewed by Police Psychology to assess where this may be indicated and suitability.

We further note that e-mental health has come of age and is now regarded as part of mainstream mental health services. In addition to mental health information, there are effective mood/anxiety treatment programs available online. E-mental health services will be an integral component of the new Victoria Police online platform. The new mobile phone Application is being modelled after the PTSD Coach Application that is popular among veteran populations.

## 7.12 Transition, retirement, keeping in touch and post-employment services

The issue of "moving people on" or assisting with exiting from VicPol was also canvassed.

> *"Some people don't believe there is anything else they can do and policing can attract individuals with romantic notions who think they have a job for life."*

It will be important to devise exit strategies that ensure members are acknowledged for their service and can be assisted with starting a new career or maximising personal opportunities.

> *"Sometimes people are not suited to it and one outcome would be to get the person to exit and get on with their lives, so you need to manage them out." (VicPol member, 37 years)*

Supervisors will need to learn to ask, "Have you thought about something else?"

> *"Police have an emotional contract with being a police member and there is a difference between the expectation of the job and what it is. Policing is like a bank account and some members invest everything but towards the end of their career, you may not be getting that emotional dividend and there is a feeling of being screwed over." (VicPol member, 32 years)*

> *"We don't want police to drop off the grid." (VicPol member, 37 years)*

The Review Team spoke with more than 30 retired Victoria Police employees (sworn and VPS). Many of these individuals had ceased their employment well over 10 years earlier. There were ample indications, above and beyond allowing for 'personal axes to grind', that many of these former members were genuinely struggling with mental health-related issues linked with their employment. These issues include depression, social isolation, relationship and family difficulties, substance misuse (e.g., self-medicating with alcohol), difficulties engaging with any local community based involvements and grappling with suicidal ideation and intrusive recollections of operational incident experiences.

Although Police Psychology and Welfare Services have recently been made available to retired members, a significant cohort of retired sworn and VPS individuals are reluctant to access these services. This is because many of these former members feel that in some way they have been damaged by their employment, or avoidance behaviours associated with traumatic stress problems have become more entrenched.

Some of these former employees have chronic mental health conditions and have established treatment relationships with health service providers outside of Victoria Police. The Review Team spoke with several former police officers who were self-funding treatment (i.e., regularly seeing a Psychologist beyond the annual Medicare Mental Health Plan limit, or paying the significant gap in Psychiatric fees).

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The Review Team noted that there is a historical legacy element contributing to this situation: some of the issues being grappled by former employees were considered to reflect the historical lack of availability of adequate services, which have progressively increased over the past decade.

Additionally, across the stories shared with the Review Team by former employees, there were also clear indications of the impact of strong mental health stigma (see Chapters 4 and 5). The historical legacy dimension would be expected to lessen over time, as Victoria Police becomes a more 'mentally healthy organisation' and individuals access support and treatment resources earlier.

The Review Team noted that, unlike the Australian Defence Force, there is no equivalent organisation like a Department of Veterans Affairs for police and emergency services workers generally in any State or nationally. The Chief Commissioner raised this very issue in a meeting with the Review Team.

The Review Team noted that The Police Association exerts considerable efforts to engage with former members through supporting a range of social activities. Recently, a Retired Peer Support Network was established by Vicki Key (retired Victoria Police Sergeant).

This network has already had strong take-up. The Review Team recommends that this network be supported and expanded, and allocated sufficient funding to maintain an appropriate minimal infrastructure.

The Review Team further recommends that all employees, when transitioning out of Victoria Police:

a. Be provided with the contact details for the Retired Peer Support Network; and
b. Undertake a mental health screening assessment and any indicated treatment/management plan be devised. Where significant mental health treatment needs are identified, then reasonable treatment costs should be funded by Victoria Police. It would be expected that most treatment needs could be managed via Police Psychology or the network of mental health specialist providers (the establishment of which is recommended previously).

Additionally, it is noted that some indicated management plans may more appropriately involve engagement with psychosocial support services, rather than clinical treatment per se.

There are a number of community-based service providers who offer these types of programs which include assistance in developing and maintaining activities of daily living, establishing and maintaining an appropriate physical exercise regime, building a social support network and increasing engagement with local community involvements.

## Recommendation:

19. Resilience content in recruit training should be refreshed and updated, and mental health literacy and physical health education content be added. This content should be positioned as 'foundational' on the same level as operational skills training and thus should also be examinable.
20. Families should be invited to attend some mental health literacy and physical health education sessions during recruit training. Further, additional family engagement initiatives should be further investigated for implementation within Victoria Police.
21. The indicated organisation-wide wellbeing monitoring regime needs to be adequately resourced, above and beyond business as usual (i.e., increased Police Psychology Unit positions as detailed elsewhere).
22. The early intervention Trauma Group Pilot Program should be expanded and adequately resourced.
23. VicPol suicide prevention initiatives, as part of the organisation-wide mental health literacy program, should be aligned with the principles of the national suicide prevention framework and be consistent with forthcoming Victorian government suicide prevention initiatives. Further, reporting on suicide in all VicPol communications should be aligned with the Australian Government Mindframe guidelines.
24. Initial contact with injured employees should be refocused around a primary ongoing single point of contact and the development of a case management plan, developed by an Injury Management Consultant/Welfare Officer, with support for mental health issues as indicated, provided by the Police Psychology Unit. This will involve the creation of an additional six Welfare Services Full Time Equivalent positions.
25. Sessional specialist mental health input should be accessed, as indicated, to advise Victoria Police and the insurer as part of the claims determination process. This should be sourced externally to keep Police Psychology Unit removed from any possible perception of conflict of interest/supporting the insurer.
26. There is a need to review accountability for return to work programs. Appropriate accountability for return to work outcomes, at the local level, should be introduced.
27. The Review Team recommends that Regional and Departmental managers are assisted by the Human Resource Department in improving the process where locally established 'temporary' placements are used, where needed, as a standard staffing option. (N.B., Existing staff funding models may need to be reviewed as part of a broader expansion of flexible employment options under this review and also the VEOHRC Report).
28. Additional options for redeployment with other organisations should be further explored.
29. An external network of specialist mental health service providers (mainly psychiatrists and clinical psychologists) should be established, with service level agreements involving up front commitment to align their clinical practice with: (a) the Guidelines on the Treatment of PTSD in Emergency Services Workers; (b) the Australian Health Benefits of Work Agenda; and (c) the Clinical Framework.
30. As triaged by the Police Psychology Unit, in collaboration with the Medical Advisory Unit, some members in rural and remote locations where there is a lack of available appropriately qualified local mental health service providers, should be offered e-treatment access to a specialist mental health service provider, such as is now available via secure video conferencing facilities (accessed via web browsers).
31. All retiring Victoria Police employees should undertake a mental health screening, and where significant work-related mental health issues are identified, then a treatment plan should be devised and funded by Victoria Police.
32. The Retired Peer Support Network should be expanded and sufficiently funded to maintain an adequate infrastructure to manage referrals and monitor service quality. Along the lines of how the Department of Veterans Affairs operates, some function should also be established to manage funding and clinical quality assurance of indicated treatments for work-related conditions.

## What would success look like?

Key indicators of success will include reduction in lost time psychological injuries and suicides – but this needs to be realistically assessed, e.g., over the subsequent 24 to 36 month timeframe.

# Chapter 8: Other Psychological Risk Issues that Impact on Mental Health

## 8.1 Sexual Offence and Child Abuse Investigation Teams (SOCITs)

*"It's just the relentless volume and type of material that overwhelms them. This work is misunderstood by many, including myself before I worked here. It's hard work – very hard." (Detective Senior Sergeant - SOCIT)*

*"I spent two days watching hundreds of videos and was feeling sick with my hand over my mouth. I went back to work the next day and started to unravel."*
*(Leading Senior Constable - SOCIT)*

*"80 percent of the past two years constantly viewing millions of sick images. I go home to my kids and it all comes rushing back." (SOCIT operative)*

*"Personal visits are needed from psychiatrists (not looking at their watches); I needed a 'work break' and one on one psych visits. We needed regular de-briefs. We needed to vary the hours – 10 -14 hr days watching vile pornography. We need help." (Leading Senior Constable - SOCIT)*

*"Yes it is frustrating when you know a victim has been abused and the matter never gets to trial, but it's the lack of understanding and support from managers that really upsets me."*
*(Leading Senior Constable – SOCIT)*

The Review Team spoke with several serving and former staff who worked in the area of SOCIT and child exploitation and exposure to child exploitation material. In several cases, their accounts were harrowing. The sometimes overwhelming exposure to this material, and dealing regularly with victims and their families over extended periods of time often without achieving any anticipated prosecution outcomes, has contributed to permanent psychological scars for some.

The practice of classifying all images obtained for prosecutions has placed an inordinate burden on officers, with no apparent correlation with increased penalties following findings of guilt. Recent legislation will allow the limiting of classification to a random sample of all material obtained. However, this has not yet been implemented due to qualification requirements. There are also operational considerations to limiting the amount of viewed material that may encourage units to examine larger amounts.

In addition to the impact of exposure and associated high workloads, it was widely reported that leadership and management behaviours have a critical impact in either accentuating problems, or buffering against their impact. The cultural challenge posed by SOCIT work in the broader Victoria Police culture has been discussed in Chapter 5 and the leadership uplift recommendations will be particularly important here to contribute to overall psychological safety risk reduction.

The Review Team considered but does not recommend implementing any 'Maximum time in position' (MTIP) approach. There are some individuals who have worked long-term in these areas and continue to be psychologically robust. The Review Team also noted, for example, that the Australian Federal Police rotation policy in this area is 'nominal': there are some individuals who seem to maintain a high level of personal wellbeing, irrespective of the duration of time working in these roles and their technical expertise is highly valued, and hence they should be able to continue.

Rather, an 'opt out' type provision, on either a temporary or permanent basis should be recognised, as may be identified via ongoing wellbeing monitoring (i.e., formal and informal wellbeing checks). Progress with the organisation-wide mental health literacy program will also assist in validating any opt out provision.

There may also be occasions where individuals need to undertake temporary alternative duties, as earlier discussed in terms of the 'interchange bench' notion. For example, in other settings when a member or their partner becomes pregnant, this has been found to be associated with a degree of increased risk and hence opting out temporarily or permanently may be an entirely legitimate (but not inevitable) consideration.

The Review Team also notes in other settings 'group wellbeing monitoring' sessions are often effectively deployed. These types of sessions are usually conducted by a psychologist, and focus on: reminding team members about early warning signs; fostering collegial support and peer early risk identification; updating on mental health risks; encouraging early help seeking; and fostering team cohesiveness, as well as offering any individual follow-up discussion as indicated.

The Review Team further concluded that the introduction of a supervision model for SOCITs would also contribute towards substantial psychological risk mitigation. This type of model typically involves coaching, problem solving and troubleshooting issues, etc. There are no well-established practices and protocols here, in terms of frequency of sessions etc. Importantly, supervisors would not need to be psychologists or other mental health professionals. In fact, the supervision model could be grafted on to the safe-t-net system.

The Review Team further recommends that additional Police Psychology Unit resources be allocated to the SOCITS, to undertake indicated mental health screening, provide psychological interventions and counselling as needed, advice to management and contribute to Sexual Offences and Child Abuse Team (Family Violence Command) development of ongoing risk mitigation initiatives.

Finally, the Review Team noted that the psychological testing of recruits is generic to crime and not specific to SOCITs. Accordingly, the Review Team recommends that a more SOCIT specific psychological testing protocol be devised, and appended to the SOCIT recruitment process as indicated.

## Recommendation:

**33. Sexual Offence and Child Abuse Investigation Teams should be allocated dedicated Police Psychology Unit support (Full Time Equivalent to be determined through further evaluation) to provide mental health screening as indicated, advice and coaching to management as required, training delivery, support for implementing supervision practices, and input into further Sexual Offences and Child Abuse Team prevention and risk mitigation initiatives.**

**34. A Sexual Offence and Child Abuse Investigation Teams 'Opt out' type provision, on either a temporary or permanent basis should be recognised, as may be identified via ongoing wellbeing monitoring (i.e., formal and informal wellbeing checks), and self-report. A maximum time in position policy is not indicated.**

**35. It is recommended that a supervision model be introduced for Sexual Offence and Child Abuse Investigation Teams, as the Review Team is of the opinion that this would contribute towards substantial psychological risk mitigation. The Review Team makes no more specific recommendation as to the type of providers and frequency of sessions, as this can be determined via the outcomes of current Sexual Offences and Child Abuse Team projects.**

# Chapter 8: Other psychosocial risk issues that impact on mental health

## 8.2 Operational Safety Tactics Training (OSTT)

The Review Team carefully considered the OSTT process as a forum to discuss mental health issues. However, practical limitations were noted with existing OSTT session time demands. To maintain local management focus and support various existing safety initiatives, it is not proposed by this Review to formally add mental health discussions to OSTT sessions at this time.

The Review Team anticipates that such mental health and wellbeing related conversations, that may be relevant to OSTT, will be satisfactorily initiated via the organisation-wide safe-t-net wellbeing monitoring system, when it is fully implemented, as well as positively influenced by the leadership uplift program. This issue could be reconsidered following full implementation and some six to 12 month operation of the safe-t-net system.

The Review Team further recommends that the Medical Advisory and Psychology Units jointly review protocols and timeframes around assessment of suicide risk and subsequent potential access to firearms. Further, the Review recommendation regarding increasing in-house specialist mental health service capability will further assist here.

At this time, the Review Team does not recommend any blanket permanent restriction on firearms access and OSTT suspension for people identified with mental health problems and suicide ideation. Whilst safety considerations are acknowledged to be absolutely paramount, it must also be recognised that *some individuals fully recover and pose no subsequent risk whatsoever.*

Hence, overall, the Review Team formed the view that these issues can be appropriately addressed through further recalibration of timeframes and clinical assessment protocols, as may be further recommended by Medical Advisory/Psychology Units, and supported through increased mental health specialist capability.

## 8.3 Discipline processes and declarable associations

*Declarable Associations (DA) Policy –*

> *"Consider the impact on your people, when most vulnerable. Look at facts, not just the process." (Sergeant)*

> *"Work was all he had and all of his support was cut off." (Leading Senior Constable)*

*Discipline Processes -*

> *"Suspension process – I could have been doing some productive work, rather than being isolated. I was no risk." (Senior Sergeant)*

> *"I am back at work now and support my team, but my thoughts of the organisation are much lower on my list of priorities." (Senior Sergeant)*

> *"I have been a police officer for 30 years and have seen many members who have struggled. You do not need psychs, you do not need therapists, you just should have told your boss." (Comment to suspended member from a senior officer)*

The Review Team spoke with several police members who described the negative impact on individuals' mental health when involved in the discipline and crime investigation process with Professional Standards Command.

Issues highlighted by interviewees included:

- Respect for the concept of people being accountable if they have done the wrong thing;
- The seemingly often excessive length of time members are under investigation;
- The potentially detrimental effect on individual wellbeing when isolated from support networks (DA policy);

- The detrimental effects on mental health (including fear of self-harm);
- The similarities between long term forced absence and long term sick leave and the comparable reduced likelihood of returning to the workplace;
- The legacy issues when members returned to the workplace;
- The inefficiency of having staff off work (suspended) when they could be otherwise usefully engaged; and
- That not all people under investigation are a threat or risk.

The Review Team noted the recent activity in this space and the information provided in the VicPol Gazette (4 April 2016) by Assistant Commissioner Brett Guerin of Professional Standards Command, that address some of the issues raised in submissions to this Review. In particular, his comments acknowledge the potential mental health impact of suspensions on members. The concurrent halving of suspensions since he assumed command, indicate that progress has occurred.

Similarly, comments around the discipline process strike at the very core of many identified examples where managers were previously reluctant to take decisive and appropriate action, at an indicated time. 'Early intervention' is a notion that is not only applicable to health-related interventions: it also applies to managers addressing behavioural issues in a timely manner and proactively holding individuals accountable for operating in manner consistent with organisational values and expected behaviours. This is a further example that provides strong justification for embarking on the organisational 'leadership uplift' discussed in Chapter 5.

In particular, submissions received on declarable associations indicated strong views that decisions in some historical cases have been overly focused on organisational reputation and perceived risk minimisation, at the unreasonable expense of fairness to the individual. Detriment to individuals' mental health is a regular and expected outcome of an investigation; however, the need to find balance between competing priorities should not preclude reasonable contact with supportive friends and colleagues. The Review Team recommends that appropriate consultation is undertaken with Wellbeing Services to ensure appropriate management of any mental health risks.

The Review Team further noted that, as a general comment from a mental health perspective, notification of termination of employment should not be undertaken on Friday afternoons.

Finally, the Review Team noted that some disciplinary processes involve significant interactions with external agencies and bodies. The Review Team recommends that other agencies ensure appropriate communication occurs regarding member welfare issues.

## Recommendation:

**36. Appropriate consultation with Wellbeing Services should be undertaken by those VicPol internal and external agencies/bodies implementing disciplinary investigations, to ensure member wellbeing is appropriately taken into account.**

# Chapter 8: Other psychosocial risk issues that impact on mental health

## 8.4 Secondary employment

There are currently 127 Australian Defence Force (ADF) Reservists in Victoria Police. Many other members also undertake secondary employment, for example, Country Fire Authority (CFA) volunteer work.

The Review Team noted that the VicPol Critical Incident Response Team (CIRT) is currently undertaking a review of secondary employment, as there are a number of ADF reservists located there.

Currently, there is no organisation-wide process to identify members undertaking military service or other secondary employment that may be associated with exposure to potentially traumatic events. The ADF does conduct post operational screens, but these individuals are not assessed on their return to VicPol or monitored in any way.

The Review Team concluded that this is a potentially significant gap and should be further reviewed by VicPol. Accordingly, it is recommended that, when available, the CIRT recommendations are considered as the basis for developing an organisation-wide policy on the mental health risk aspects of secondary employment.

### Recommendation:

**37. It is recommended that the outcomes of the Critical Incident Response Team review in relation to the wellbeing management of VicPol members who are also Australian Defence Force Reservists, be considered as a basis for developing an organisation-wide policy and process for managing any potential mental health impacts of secondary employment.**

## 8.5 Career breaks

Police staff regularly report stress and fatigue from the relentless workload and demanding nature of both frontline police duties and the 24-hour shift cycle. It is common, therefore, for police to consider other employment due to these (and other) factors, during their police careers. There has also been a growing organisational understanding of the benefits of members undertaking work in other streams or fields.

As mentioned earlier in this report, 'interchange options' are currently limited and not always created in a strategic or effective fashion, hence the proposal in this report, to enhance and increase the use of these holding positions. In any event, short-term positions will rarely accommodate all the needs of managers and individuals in either a pro-active or reactive sense. As both a proactive measure and to increase the limited prevention and recovery opportunities available for Return to Work (RTW), further alternate options need to be identified.

The Blue Paper (2014) strategic initiative of 'Building capability: people & technology', provides further guidance in this area.

> *"Police officers in 2025, like those currently serving, will need to have the resilience to deal with the stresses and strains of the 24/7 work environment." (Blue Paper - p.40)*

> *"Physical standards should be confirmed prior to progression payments, promotion and OSTT... Psychological health must also be both an integral component of selection, and supported throughout a police officer's career." (Blue Paper - p.42)*

> *"Victoria Police needs to do more to remove the stigma around psychological injury. Encouraging ... increased reporting of psychological injury, just as is done in the general community, will lead to better management through early intervention, and a reduction in injuries." (Blue Paper – p. 45)*

Further relevant discussion on the issue of workforce and career planning is to be found in the VEOHRC 2015 report on behaviours in Victoria Police.

The concept of career breaks has been provided increased prominence with the establishment of the new Police Registration and Services Board (PRSB) and the commencement of the Registration Division in April 2014.

Career breaks are usually by either long service leave, limited secondments outside of Victoria Police, approved leave without pay (LWOP) or resignations. All have limitations in their current form; however, the current cost to the organisation in people and dollar terms, (read mental health problems, absenteeism, conflict, etc.) presents a persuasive case for change.

Leave Without Pay:

- Is usually restricted for periods up to 12 months (VPMPG) - and is often misunderstood or actively discouraged (e.g., anticipated staff impact and personal reasons); and is exacerbated by the existing counting and back-fill model; and
- Options to expand this are based on the broader member health perspective.

There have been reports to this Review that LWOP has often been met with resistance by managers, concerned over the impact of service delivery with reduced staff, as back-fill is rarely provided for LWOP absences. Hence it appears that a lack of process and policy options prevent, in many cases, beneficial breaks for staff. This, in turn, compounds identified stressors in individuals and contributes to further deterioration in wellbeing.

Overall, supporting the notion of 'career breaks', is proposed as part of a suite of initiatives to provide mental and physical health benefits for staff. Further work will be required by Victoria Police to progress this towards active and flexible policy.

One of the concerns identified with extended periods of absence is the issue of police powers and the oath of office. This is increasingly relevant when LWOP involves external employment. The Victoria Police Act provides for the suspension by the Chief Commissioner of police powers and the removal of the obligations of the oath of office for set periods. This process would, to a significant extent, address those concerns.

The Review Team identified the following considerations for enhancement:

a. Broadening the accessibility of LWOP;

b. Recruiting to provide backfill as part of the organisational structure and capacity;

c. Accepting this as the reasonable cost of doing business;

d. Undertaking strategic change to reduce the cost of absence and WorkCover premiums;

e. Allowing people to have other experiences and return to policing;

f. Providing respite from the demands of policing;

g. Potential for expansion of breaks to other agencies, sectors and police forces or for personal and wellbeing reasons;

h. Potential expansion of work opportunities during LWOP;

i. The PRSB has a strong interest in external mobility initiatives and collaboration with the Registration Division is proposed;

j. Registration process is accessible while in this stream (Police Profession Register);

k. Consolidation and expansion of the Police Profession Register process provides a base for management of some career breaks; and

(N.B., at the time of writing, 112 applications had been made to PRSB, with 44% progressing to registration, 16% to registration and appointment. Remainder are in progress, withdrawn or rejected.)

# Chapter 8: Other psychosocial risk issues that impact on mental health

l. Staff funding and counting model would need variation (Government).

(N.B., as with interchange options, existing staff funding models may need to be reviewed as part of a broader expansion of flexible employment options under this review and the VEOHRC Report.)

**Recommendation:**

**38. As part of the VicPol Mental Health Strategy, further consultation should be undertaken in conjunction with the Police Registration and Services Board, to develop appropriate career break options, including:**

- **Planned (and unplanned) career breaks;**
- **Expansion of the leave without pay policy;**
- **Review staff funding and counting model; and**
- **Consider the existing process around suspension of police powers (VP Act s.54) for extended periods of absence.**

## 8.6 Police honours and awards and psychological injury

VicPol Honours and Awards have experienced increasing applications from members who have sustained mental health related injuries (e.g., developed PTSD as a direct result of exposure to single extreme operational incidents or multiple successive traumatic incidents).

The 'Police Star' is a distinguished award and the processes involved to determine this award have historically been more oriented towards addressing members who may have sustained physical injuries. More specifically, the wording of the criteria appears to privilege physical injuries, and probably unintentionally from the present perspective, seem to be biased against mental health-related injuries.

The Review Team noted that members who sustain, for example, serious back injuries in the line of duty, may well have pre-existing spinal degenerative processes associated with an increased underlying physical vulnerability – but the focus is on the impact of the contemporary operational involvement.

This should be no different with a mental health related injury – where the member was fully functional until the time of the particular operational incident involvement, any underlying predisposing factors are not particularly relevant.

The Review Team concluded that it is now timely to address and update these Award criteria. The principle involved is that there should not be any discrimination between physical and mental health related injuries. Hence the Review Team recommends that Police Honours and Awards undertake a review of relevant criteria and processes, in conjunction with the Police Psychology Unit, and ensure that they are consistent with the broad intent and recommendations of this Review.

The final issue the Review Team would like to comment on is of members who have died by suicide and the increasing requests from their families for them to be recognised via the Police Honour Roll. This is evidently a highly sensitive issue for these families. The Police Honour Roll recognises officers who have died in the line of duty. There are criteria for recognition that are determined by the National Police Memorial Coordination Committee. Currently, members who die by suicide are not eligible. The dilemma is this: for members who die in the line of duty there is an unequivocal primary relationship with their employment; for members who die by suicide, the contributing factors are typically multiple and may include a work contribution, or may not include any direct relationship with work.

As far as the Review Team could determine, it would appear inadvisable to proceed down any pathway of attempting to assess and differentiate between suicides that have a significant work component and those that do not, with all the ensuing controversy and overlay of emotional responses that this process would inevitably generate. Perhaps the solution will lie in developing another appropriate form of recognition of these members. The Review Team recommends that VicPol further review this issue, and consult with other jurisdictions who face similar challenges.

## Recommendation:

**39. Honours and Awards undertake a review of relevant criteria and processes, in conjunction with Police Psychology Unit, to ensure that they are updated and consistent with recommendations of this review.**

# Chapter 9: Mental Health Review Recommendations Rapid Impact?

Overall improvement in Victoria Police mental health, wellbeing and suicide prevention outcomes is predicated on progress with the three key pillars this Review has recommended to underpin the VicPol Mental Health Strategy, namely:

(1) the organisation-wide mental health literacy program (key early intervention initiative);

(2) leadership culture change program (key prevention initiative); and

(3) full implementation of the safe-t-net wellbeing monitoring system (key prevention and early intervention initiative).

Given that some VicPol Mental Health Review recommendations, particularly the indicated leadership culture change program, will require at least three years to demonstrate significant impact, where might more immediate impacts be achieved?

In response to this question, the Review Team offers the following responses:

(1) The evident resonances between the VEOHRC and Mental Health Review recommendations can be productively exploited to drive the need for rapid change and inform a communication strategy.

(2) The Review Team concluded that VicPol can further utilise extant Zero Harm data to more vigorously and immediately, identify and target at-risk stations and work groups with indicated interventions. The recommended safe-t-net early intervention approach described in the body of this report – involving leadership coaching and development support and team building interventions, could be effectively utilised here. As earlier noted, the early intervention team should include a HR specialist with leadership development expertise and a Psychologist with organisational psychology expertise. There will need to be realistic timeframes established for improvement expectations to be achieved, and then if not, a process devised regarding how leaders who are identified as not being capable of stepping up in terms of people-focused leadership requirements will be dealt with in an appropriately organisationally supportive, but also accountable manner.

(3) The recommended organisation-wide mental health literacy program could be powerfully kick-started soon with a strong communication campaign, and launch of the recommended lived experience video vignettes that include senior leaders.

(4) Moreover, this could be supported by a strong coordinated message from the Chief Commissioner regarding the organisational changes that will occur in response to the VEOHRC and Mental Health Review Reports.

(5) Further, the desired state whereby VicPol employees at all levels are expected to operate in their day-to-day work environments in a manner consistent with re-launched organisational values and expected behaviours, could also be rapidly communicated.

(6) The combined impact of (2), (3) and (4) could be expected to achieve some direct engagement with frontline employees and also stimulate some 'bottom up' activity and empowerment, whereby frontline employees start to develop confidence about, for example, no longer needing to put up with particular behaviours they have hitherto been exposed to in their team environments; feeling more confident about raising concerns with less fear of reprisal (and that when issues are raised, they will be addressed); that their concerns will be responded to appropriately; and seeking help earlier where needed[38] .

Otherwise, the full implementation of the recommended initiatives, particularly the three core pillars noted above, will be required to achieve genuine and sustained improvement in mental health, wellbeing and suicide prevention outcomes.

38. The Review Team noted that some interviewees reported that they had considered contacting VEOHRC but did not because they "didn't believe anything would come of that contact". They reported contacting us because their perception had changed since the VEOHRC Review had concluded, and they now believed that there are signs that issues raised by VEOHRC are being addressed.

*"Leadership culture change is vital to improve mental health, wellbeing and suicide prevention outcomes. This is the only way to reduce the deeper layer of mental health stigma and increase early help seeking behaviour."*

# Appendix A: Environmental Scan

This is a brief survey of international responses to mental health issues in policing and other emergency services. The survey focuses on Canada, the United Kingdom (UK) and the United States of America (USA) as countries where such services are culturally similar to those in Australia, including Victoria Police.

## Canada

The Mental Health Commission of Canada is currently rolling out to police organisations across the country a training program about mental health called **The Road to Mental Readiness (R2MR)**.

R2MR was originally developed by the Department of National Defence and is part of a broader strategy called Canadian Opening Minds, self-described as the "largest systematic effort in Canadian history focused on reducing stigma related to mental illness". As well as the reduction of stigma, R2MR seeks to develop resilience and to educate all levels of police about mental health.

R2MR engages with police members, and families, at all stages of their career. Significantly, the program aims to educate both police employees and police leadership. This twofold focus highlights the nexus between these elements in delivery of a successful mental health program.

The **Tema Conter Memorial Trust (TCMT)** is the Canadian national provider of peer support, family assistance and education, research and training about/for public safety (emergency services) and military personnel. It focuses on operational stress and/or PTSD as well as research, education and training.

TCMT identifies two core elements to an effective mental health program: public support and research. Public support includes peer support and family assistance, referrals, consultative services, speakers, scholarships and training. Worth noting here is an emphasis on early-intervention strategies as well as education. TCMT also engages in research around best practices in mental health—and provides a comprehensive listing of such research on its website.

The website itself is a good portal to police members and mental health professionals alike. Of particular interest is Resources: a range of tools from studies undertaken by TCMT or other bodies as well as self-tests from a similar range, apps and even songs of inspiration!

**Set for Life** is a City of Montreal Police Service organisation that aims to prevent suicide in the police community. It has four components comprising education, on-site workshops aimed at developing team competence around mental health, leadership training, and a telephone support service.

Again, this multi-faceted approach signals recognition of the need to address mental health in cultural terms rather than as individual cases. Of additional interest here is the emphasis on team competence and complementarity of the roles of different 'stakeholders' in the workplace. The telephone support service is staffed by police personnel trained specifically for this task.

**Badge of Life** is a Canadian (and USA) mental health program formed by active and retired police personnel, with health professionals and 'surviving families'. It focuses on Posttraumatic Stress Disorder and other forms of 'emotional stress'—within a mental health framework called the Emotional Self-Care Program (ESC).

This program again includes multiple components, including an annual mental health check, peer support officers, annual training and, interestingly, comprehensive mental health education as part of the core training of police personnel.

See also the **Royal Canadian Mounted Police Health Services**—with particular reference to its Mental Health Strategy.

# Appendix A: Environmental Scan

**Note:** On 1 February 2016 a range of preventative initiatives in relation to mental health issues for Ontario first responders was announced. These particularly focused on PTSD (awareness, elimination of stigma, annual leadership summit, best practices and prevalence studies, resources and research). One of the arguments in presenting the initiatives was about the cost of mental illness to the Canadian economy—and that mental illness is 'the number one cause of disability claims in Canada'.

## United Kingdom

The **Blue Light Programme** is a multi-dimensional program aimed at improving mental health for UK emergency services personnel. It includes a telephone information service (support, counselling and 'signposting'), booklets, webinars, a pledge (and action plan to implement it), peer network events, the 'Champion' scheme—whereby an individual 'takes action in the workplace to raise awareness of mental health issues and challenge mental health stigma'—resilience courses, line manager training and an online forum to share experiences. Website offers registration for updates and event information as well as Twitter. Resources are available online.

**Call4Backup** is a support service staffed by volunteers operating out of London and Essex. Support is via phone, email or text and areas of assistance identified on website are legal, financial, well-being and domestic—with the proviso that there are many other areas that are covered.

The service also organises fundraising and memorial events—and has a merchandising arm that not only raises funds but also mental health awareness.

Call4Backup is staffed by volunteers comprising serving and retired police officers who are trained for their role.

## United States of America

**Everyone Goes Home** is a national firefighter and emergency services program aimed at 'life safety'. It has 16 'Life Safety Initiatives' with the first of these being cultural change. This encompasses encompassing leadership, management, supervision, accountability and personal responsibility.

Other initiatives include accountability, risk management, empowerment, training, fitness, public education and research. Each initiative has a list of resources, research and news.

**In Harm's Way** is a federally funded program that offers training and workshops aimed at suicide prevention amongst police. It also provides resources and statistics, on the issue of police suicide including prevalence, causes and preventative strategies.

Stress First Aid is a training program around stress for first and emergency medical services. It is part of the Fire Hero Learning Network, an online resource for training firefighters. The approach has been taken up by other emergency services.

Stress First Aid outlines the 'seven Cs' of stress first aid: Check, Coordinate, Cover, Calm, Connect, Competence, Confidence. The program is focussed on colleagues supporting each other and having sufficient mental health awareness to do this in a constructive way.

**Cop2Cop** is a state-wide 'law enforcement officer crisis intervention services' program in the State of New Jersey. It was set up after a series of police suicides in the mid to late 90s. The program has a focus on suicide prevention and mental health support, and is focussed around a 24-hour helpline for not only police members but also, importantly, their families. Helpline staffed by mental health professionals, and two strands of retired police officers—1. trained peer supporters and 2. licensed clinical social works ('cop clinicians').

# Appendix 1: Environmental scan

Services offered through the helpline include: peer and clinical support services, clinical assessments, referrals and critical incident stress management. Note: All personnel are trained in onsite debriefing and other critical incident stress management. Debriefing methods used follow the International Guidelines established by the ICISF.

Finest Health is a 'confidential' website created by the New York Police Department (NYPD). It aims to increase awareness and provide information about personal health and fitness for both NYPD employees and their families. Fitness is defined as physical and mental health.

One component of this is a 24-hour telephone service within the Employee Assistance Unit (EAU) staffed by peer Counsellors, uniformed and civilian, who are all active members. The staff mandate is to 'Listen and Refer'.

### Other resources

Royal Canadian Mounted Police Mental Health Strategy (2014-2019):

World Health Organization's Closing the Gap Programme,

See Me campaign, Scotland

Like Minds, Like Mine, New Zealand

Italian Ministry of Health campaign (http://www.campagnastigma.it/).

YouTube: 'Code Nine, Officer Needs Assistance".

*Based on this scan, the Review Team did not identify any additional initiatives that are recommended to Victoria Police for further consideration at this time, as part of the development of the Mental Health Strategy. We further concluded that safe-t-net is a world class, innovative and leading edge wellbeing monitoring system. The proposed VicPol mental health literacy program is also consistent with international best practice.*

*"It is not a weakness to seek help. The stigma that exists is police stigma. If a police member admitted to having mental health issues, there is a belief that this would erode confidence in police, but this is narrow minded and pig ignorant."*

# Appendix B: Acronyms and Glossary of Terms

| Acronym | Definition |
|---|---|
| ADF | Australian Defence Force |
| AHPRA | Australian Health Professionals Registration Authority |
| AV | Ambulance Victoria |
| CEM | Child Exploitation Material |
| CIRT | Critical Incident Response Team |
| CPSU | Community and Public Sector Union |
| DA | Declarable Associations |
| DTA | Direction to Attend |
| DVA | Department of Veterans Affairs |
| EAP | Employee Assistance Provider |
| EAS | Employee Assistance Service |
| FTE | Full Time Equivalent |
| GP | General Practitioner |
| HR | Human Resource |
| ISCRR | Institute for Safety, Compensation and Recovery Research |
| KPI | Key Performance Indicator |
| LWOP | Leave Without Pay |
| MTIP | Maximum Time in Position |
| OSTT | Operational Safety Tactics Training |
| PDA | Professional and Development Assessment |
| PRSB | Police Registration and Services Board |
| PSO | Protective Service Officer |
| PTSD | Posttraumatic Stress Disorder |
| RTW | Return to Work |
| SOCIT | Sexual Offences and Child Abuse Investigation Team |
| SOCAT | Sexual Offences and Child Abuse Team |
| Sworn | Police Officers and Protective Service Officers |
| StEPS | Systems Evaluation for the Prevention of Suicide |
| TPA | The Police Association |
| VEOHRC | Victorian Equal Opportunity and Human Rights Commission |
| VicPol | Victoria Police |
| VPS | Victorian Public Service |
| WA | Western Australia |

If this report causes you distress or if you require access to professional support and advice in relation to a work or personal related crisis, current and former Victoria Police employees can phone the 24 hour Support line on (03) 9247 3344. Members of the community can phone Lifeline on 13 11 14 or beyondblue on 1300 22 4636.

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