AFP
AUSTRALIAN FEDERAL POLICE

28 March 2018

Senate Estimates Committee Secretariat
Legal and Constitutional Affairs Legislation Committee
PO Box 6100
Parliament House
Canberra ACT 2600

Dear Secretariat

At the AFP Senate Estimates Committee hearing held on 27 February 2018, the Committee requested a copy of the recently released Phoenix Australia report on Mental Health in the AFP.

I am pleased to provide a copy of the requested report for dissemination to Committee members.

Yours sincerely

Philippa Crome
National Manager
People, Safety and Security

Attachment – AFP Structural Review, Reform and Policy Development on Mental Health: Final Report

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POLICING FOR A SAFER AUSTRALIA

PHOENIX AUSTRALIA | Centre for Posttraumatic Mental Health

AFP Structural Review, Reform and Policy Development on Mental Health: Final Report

January 2018

THE UNIVERSITY OF MELBOURNE

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Executive summary

The Australian Federal Police (AFP) engaged Phoenix Australia Centre for Posttraumatic Mental Health (Phoenix Australia) to undertake a Structural Review, Reform and Policy Development on Mental Health (hereafter referred to as a Mental Health Review) of the AFP. This request came in the context of mental health being identified as a key priority within the AFP.

We do not underestimate the challenges involved for organisations opening themselves up for external review of their approach to managing mental health issues. We commend the AFP for its open and transparent approach, facilitating our engagement with staff across all levels of the organisation. We also thank every member of staff who gave their time to contribute to the review in good faith. We sincerely hope that our review and recommendations will provide a roadmap for ongoing improvement within the AFP.

Over the past two years the AFP has begun implementing a series of initiatives aimed at improving mental health outcomes for AFP staff. The Draft AFP Mental Health Framework 2016-22 and the Draft AFP Mental Health Strategic Action Plan 2016-22 have been developed to guide these improvements. The current review builds on these initiatives to ensure that the AFP has in place a multi-faceted, evidence-based, and comprehensive mental health program tailored to the specific needs of AFP staff.

The review consisted of three phases:

1. A review of AFP policy and procedure documents related to staff wellbeing;
2. Staff consultation through face-to-face interviews with leaders, union and staff support services, focus groups with staff and families, and written submissions; and
3. An online staff survey.

The AFP is a complex organisation, made up of multiple heterogeneous parts. Whilst it is apparent that some work areas within the organisation, such as child exploitation, counter terrorism and overseas deployment, face particular psychological risks, perceptions of inadequate resources and excessive demands were identified as an issue throughout the organisation. The complexity of the organisation and the geographical spread of staff, create unique challenges for the organisation in meeting the mental health needs of its staff. In addition, we recognise that concerns about staff with mental health issues are compounded within the AFP by the nature of the work that they do and in particular, the carriage of firearms.

With respect to the current approach to mental health support, the review identified that there are a range of supports currently available to staff but there is little coordination or clarity of respective roles and responsibilities between them. In addition, there is limited accountability for services provided and quality assurance mechanisms are absent or inadequately

resourced. There was also evidence of an inconsistent application of the range mental health services that did exist. Furthermore, it was clear that managers are not well equipped to support the mental health of their staff.

The survey provided a 'snapshot' of current wellbeing. Self-report measures (which importantly cannot be used to formally diagnose mental health conditions) identified that almost one-quarter of survey respondents were experiencing moderate to high levels of current psychological distress. More specifically, 14% reported symptoms consistent with a diagnosis of depression, 9% reported symptoms consistent with a posttraumatic stress disorder (PTSD) diagnosis, 6% reported clinically significant anxiety, and 9% reported problematic alcohol use. Please note that self-report rates are often higher than rates based on structured clinical interviews and so these rates are likely to overestimate rates of diagnosable mental health disorders. In addition, as they are based on staff who elected to complete the voluntary survey, they should not be interpreted as representing rates across all AFP staff.

The purpose and methodology of this study do not permit direct comparisons with mental health prevalence rates in the Australian community (Slade et al., 2009) or even rates in a more comparable work population, the Australian Defence Force (McFarlane, Hodson, van Hooff, & Davies, 2011). The key differences lie in the AFP survey being an open invitation to staff rather than a selected representative sample, based on self-report rather than structured diagnostic interview, measuring current symptoms rather than symptoms in the past 12 months, and being conducted many years later.

Nevertheless, as a point of reference, the 12-month prevalence of mental health disorders reported in the Australian Defence Force (ADF), and a community sample matched to the ADF for age, gender and employment status (McFarlane et al., 2011) are as follows: affective disorder (including depression), 9.5% in the ADF and 5.9% in the matched community sample; PTSD, 8.3% in the ADF and 5.2% in the matched community sample; anxiety disorder, 14.8% in the ADF and 12.6% in the matched community sample; and alcohol use disorder, 5.2% in the ADF and 8.3% in the matched community sample.

The survey also provided a snapshot of staff perceptions of current supports. The survey identified that staff generally do not feel supported by their managers and are concerned about seeking help because of concerns about confidentiality and impact on career. Staff are most likely to seek support from family and friends, their general practitioner or an external/private psychologist. With respect to services provided by the AFP, there is general dissatisfaction with the employee assistance provider (EAP) and insufficient availability of Psychological Support Services. The rehabilitation and compensation process for injured workers is experienced as disjointed and unsupportive, adding to distress.

These findings suggest that significant further work is needed to create a workplace environment within the AFP that is conducive to good mental health. In particular, staff need to feel supported at a local level (by management) and to see evidence through sustained action that the organisation's stated commitment to improving the mental health of staff is genuine. A high priority for the AFP will be to substantially redevelop its staff support system.

In making recommendations for change the review team considered, first and foremost, the findings of the review with respect to the nature of the organisation, including structure, function and geographical diversity, the range and prevalence of staff mental health issues, the adequacy of current staff support services and current barriers to care. Although shortcomings were observed in the current support services, each component of the service represents an important component of a comprehensive approach and the review team believed that the services should be remediated improved rather than replaced.

The review team benchmarked the AFP against each element of the best practice framework for managing mental health in high-risk organisations that Phoenix Australia has developed on the basis of the research literature and our own extensive experience in working with high-risk organisations. Recommendations have been made for each element of the framework and arranged in order of priority (Priority 1, commence implementation within 1 year; Priority 2, commence implementation within 1-2 years; Priority 3, commence implementation within 3-5 years).

Where there is an important sequencing in the timing of changes this has been noted. The recommendations are intended as a blueprint that can be used to guide continual improvement over the next 3-5 years.

Important to say that we do not underestimate the time, fortitude and commitment that will be required to implement the recommendations from the review. We appreciate the challenge for the AFP of striving to meet the expectations of staff, while ensuring that changes and new initiatives are introduced in a considered and sustainable way. That all of this occurs within an environment of fiscal constraint, public interest and media attention, increases the challenge many fold.

Phoenix Australia recommendations

Recommendation
1. Organisational Factors
Areas of concern noted but recommendations are beyond the scope of this review.
2. Mental health policy framework
Priority 1 commence implementation within 1 year
RECOMMENDATION 1 Build on the current mental health strategic plan to develop a comprehensive framework for the evaluation of mental health policy implementation that: a) identifies the gaps in existing policy documentation; b) delineates a plan for the development of the necessary policy documents; c) addresses how the policy is to be disseminated across the organisation; d) outlines what training and support is to be provided to staff who have responsibility for implementing components of the policy; e) details the intended impacts of the policy; and f) explains how these will be measured.
RECOMMENDATION 2 Develop a policy and procedure document that outlines: a) the role of each component of staff support services; b) the relationships between each component, reflecting a stepped care approach; c) referral and access pathways; d) confidentiality and privacy considerations; e) governance arrangements; and f) quality assurance mechanisms.
Priority 2 commence implementation within 1 - 2 years
RECOMMENDATION 3 Introduce an electronic health record that can be shared across each component of staff support services.
3. Managers and leaders
Priority 1 commence implementation within 1 year
RECOMMENDATION 4 To promote help-seeking, communicate to staff that senior leadership views mental health injuries as able to be rehabilitated until proven otherwise, and provide clear guidelines around when and why decisions relating to changes to operational status will be taken.
RECOMMENDATION 5 Develop policy and procedure documents that provide guidance to managers on how to manage mental health concerns in their staff, including how to identify mental health issues, make necessary referrals, and make decisions about operational issues such as security clearance and the removal of accoutrements. These documents should specifically address how policy and procedures apply in remote and regional areas.
Priority 2 commence implementation within 1 - 2 years
RECOMMENDATION 6 Include leadership and people management skills as key performance indicators in the position descriptions for all managers in the AFP.
Priority 3 commence implementation within 3 - 5 years
RECOMMENDATION 7 Establish compulsory leadership training as a prerequisite for promotion to management positions across the AFP. This should be face-to-face training, wherever possible.
RECOMMENDATION 8 Ensure that all managers within the AFP undergo mental health and psychological first aid (PFA) training on a regular (2-3 yearly) basis to maintain currency. After the initial training, refresher training could be conducted online.
4. Psychological health and wellbeing support services
Priority 1 commence implementation within 1 year

RECOMMENDATION 9 Establish a stepped care approach to mental health support to ensure that care is coordinated and commensurate with need. Funding of mental health support should also be centralised to avoid duplication.
RECOMMENDATION 10 With oversight from Organisational Health, establish the role and competencies of Psychological Support Services as coordinating and managing mental health promotion initiatives as well as the range of psychological health and wellbeing support services. This includes: supervision of welfare officers and chaplains; clinical assessment / triage / referral to external providers (EAP and external mental health specialist practitioners); consultation and liaison with rehabilitation providers; and quality assurance and contract management of external providers.
RECOMMENDATION 11 Increase funding to Psychological Support Services to a level commensurate with national benchmarks of approximately 1:250 staff. This would need to be accompanied by a clear mandate for the service to maximise and prioritise what it contributes to the support system. Where possible, allocate Psychological Support Services staff to specific regions and operational areas in order to increase their profile, accessibility and acceptability.
Priority 2 commence implementation within 1 - 2 years
RECOMMENDATION 12 Develop a brochure for staff and families that describes the range of psychological support that is available to them in a stepped care model. In this brochure clearly explain who delivers what interventions or support in each level of care and provide guidance on selecting a service provider based on need and personal preferences (e.g., spiritual guidance, peer who understands the work context, independent person).
5. Level I interventions for all staff
Priority 1 commence implementation within 1 year
RECOMMENDATION 13 Further develop the Critical Incident policy to ensure consistency with best practice approaches (e.g., PFA), to assist welfare officers and managers to identify signs of concern, and to provide information on referral pathways if required.
Priority 2 commence implementation within 1 - 2 years
RECOMMENDATION 14 Promote the self-care component of the stepped care model through a service-wide roll out of mental health first aid and skills training on looking after yourself and looking out for your mates. A team-based approach would be ideal to promote a sense of shared responsibility. Provide backfill or overtime to ensure that staff are given the necessary time to take part in the roll out.
Priority 3 commence implementation within 3 - 5 years
RECOMMENDATION 15 Implement flexible solutions for physical fitness programs and resources that are commensurate with the role requirements of staff, and available regardless of location. For example, in regions without access to AFP facilities, the AFP should support staff access to locally available health and fitness activities.
6. Level II interventions for staff with mild or emerging signs of mental health concerns
Priority 2 commence implementation within 1 - 2 years
RECOMMENDATION 16 Return responsibility for managing the EAP contract to Psychological Support Services staff who are well placed to determine whether the qualifications, experience and supervision of the EAP is appropriate and whether their approach to service provision reflects best practice. This should occur only after the recommendations in relation to Psychological Support Services (resourcing and quality assurance) have been implemented.
RECOMMENDATION 17 Undertake a review of the EAP contract, including the suitability of the current EAP, to ensure that individuals providing services to AFP staff are appropriately

qualified (preferably as clinical psychologists), understand the work of the AFP (cultural competence) and provide consistency in service provision (i.e., individuals see the same counsellor for each of their up-to-six sessions).
RECOMMENDATION 18 To avoid unrealistic expectations, provide information to staff on the service, and limitations to service, provided by the EAP. This may be in the form of a regular staff information session provided by the EAP where concerns can be addressed.
7. Level III interventions for staff with a mental health disorder
Priority 1 commence implementation within 1 year
RECOMMENDATION 19 When referrals are made to external mental health specialists, the AFP should provide specific information regarding AFP's operational requirements and risk assessment procedures (e.g., management of, and access to, firearms).
Priority 2 commence implementation within 1 - 2 years
RECOMMENDATION 20 Improve the process and outcomes of return to work following mental health injury by training Injury Management case managers in mental health first aid, and establishing a collaborative approach between Injury Management and Psychology Services towards agreed goals. This should follow the increase in resourcing to Psychological Support Services.
RECOMMENDATION 21 Establish a patient-centred approach to claims management in collaboration with Comcare to minimise the distress associated with injury claims and the associated potential for exacerbation of injury.
RECOMMENDATION 22 Explore the potential for a system of non-liability health care for mental health conditions amongst sworn members and PSOs, enabling immediate access to care.
RECOMMENDATION 23 Provide staff with transition counselling if they are unable to return to previous role after mental injury.
Priority 3 commence implementation within 3 - 5 years
RECOMMENDATION 24 Engage the services of external mental health specialists with experience and expertise in working with emergency services personnel and/or Defence. For the sake of efficiency and consistency in service, consider engaging the services of an existing organisation with national reach.
8. Monitoring wellbeing
Priority 2 commence implementation within 1 - 2 years
RECOMMENDATION 25 Incorporate mental health questions into the annual AFP survey and use the results to: a) monitor overall staff wellbeing, and b) evaluate the impact of mental health and wellbeing policies, procedures, and support services.
RECOMMENDATION 26 Develop an information management system linked to HR systems to track staff exposures to trauma and other stressors as well staff absenteeism, to enable managers to monitor exposures and staff wellbeing.
RECOMMENDATION 27 Implement and encourage staff to use an anonymous online survey that allows them to monitor their own wellbeing on a regular basis, provides feedback on their current (and, ideally, past) wellbeing levels, and makes recommendations for self-help, peer/chaplaincy support, EAP, or specialist mental health treatment based on their responses.
RECOMMENDATION 28 Broaden routine and regular mental health screening and monitoring processes to all high-risk areas of the organisation. Identification of high-risk areas should be informed by an up-to-date critical incident register, which includes exposure to psychological risk. Targeted screening with a mental health professional should be conducted every 6-12

months for staff in high-risk roles, depending on number of critical incidents experienced and/or levels of cumulative exposure to potentially traumatic events. Monitoring of staff working in these areas should continue annually for two years post-rotation.
RECOMMENDATION 29 A two-phased approach to screening should be undertaken after deployment. An initial screen within the first two weeks would determine any immediate mental health needs and provided targeted psychoeducation on readjustment risks. A subsequent screen, up to six months later, would assess readjustment and identify any delayed mental health concerns.
9. Separation from the organisation
Priority 3 commence implementation within 3 - 5 years
RECOMMENDATION 30 Prepare staff for separation from the AFP though the provision of: a) transition seminars and information packs on job seeking, financial matters, and health and wellbeing; and b) individual consultations with an HR staff member to develop a transition plan and refer to counselling/coaching as required.
RECOMMENDATION 31 Support the establishment of an ex-employee network as a source of mutual social and practical support and advice. The AFP's role in this network would not be to run it but to provide practical support, guidance and ongoing connection, for example, drawing upon the experience of ex-employees for the benefit of new recruits and serving members.
10. Engagement with families
Priority 2 commence implementation within 1 - 2 years
RECOMMENDATION 32 Include a session for families at recruit training to provide information (e.g., what it is like to have a family member in the service, simple self-care strategies, professional health and welfare resources) and to encourage mutual support networks. This could be supported by a family portal on the Hub.
Priority 3 commence implementation within 3 - 5 years
RECOMMENDATION 33 Establish mechanisms for ongoing two-way communication with families including regular (e.g., monthly) information bulletins, provision of a point of contact within psychology services for family staff, and annual family days across AFP work locations. These mechanisms should be used to reinforce and build upon the family session in recruit training. This is particularly important while the member is on overseas deployment.
11. Continuous improvement
Priority 1 commence implementation within 1 year
RECOMMENDATION 34 Although we understand that the Mental Health Strategy Board is administrative rather than clinical, its role in shaping the mental health strategy indicates that the Board should include at least one mental health professional.
Priority 2 commence implementation within 1 - 2 years
RECOMMENDATION 35 Use the electronic health record to generate high level summary statistics of mental health issues across the organisation for regular review by the Commissioner via Organisational Health Branch, or other appropriate leadership group.
RECOMMENDATION 36 Have each component of the wellbeing support services prepare an annual report to Organisational Health Branch on their activities and outcomes.
RECOMMENDATION 37 Review and benchmark the approaches used by psychological and welfare support against best practice on a three to five-yearly basis to ensure they keep abreast with best practice.

Background to the review

The Australian Federal Police (AFP) engaged Phoenix Australia – Centre for Posttraumatic Mental Health to undertake a Structural Review, Reform and Policy Development on Mental Health (hereafter referred to as a Mental Health Review) of the AFP. The agreed scope of the work to be undertaken is outlined in the Work Order Australian Federal Police Mental Health Review (PRN: RES RFT 2016; SON: 3352211) included in *Appendix 1: Scope of Work.* Background information about Phoenix Australia is included in *Appendix 2: About Phoenix Australia.*

About the AFP

The AFP is the Australian Government's policing agency and a key member of the Australian law enforcement and national security community. The AFP has many purposes including:

- Investigating complex, transnational, serious and organised crime
- Countering fraud and corruption
- Disrupting money-laundering and recovering the proceeds of crime
- Protecting Australians and Australian interests from terrorism and violent extremism
- Delivering a national counter-terrorism first response capability focused on aviation security and critical infrastructure
- Providing community policing services in the Australian Capital Territory (ACT) and the territories of Christmas Island, Cocos (Keeling) Islands, Norfolk Island and Jervis Bay
- Contributing to Australian international law enforcement interests through cooperation with key international partners and responds to emergencies, law and order capacity-building missions and internationally mandated peace operations
- Developing unique capabilities and exploits advanced technology to provide utmost value to Australia's national interest
- Providing a national protection capability for specific individuals, establishments and events identified by the Australian Government as being at risk.

According to Commissioner Colvin the role of the AFP has evolved over time:

> *The Australian Federal Police (AFP) must deal not only with many traditional crime types that have evolved but also with an increasingly broad range of new and complex crime types. This creates a dynamic environment in which the AFP is uniquely placed to operate. We have capabilities and a workforce that allow us to operate locally, nationally, internationally and in cyberspace – protecting Australians and Australian interests from criminal harms wherever they may arise.*
>
> (Source: Australian Federal Police (2017) *Annual Report: 2016-17)*

Organisational structure

The AFP has an organisational structure that comprises three key elements - Operations, Capability and Capacity. Two Deputy Commissioners are responsible for delivering Capability, one Deputy Commissioner is responsible for Operations, and the Chief Operating Officer is responsible for Capacity. There are 15 business areas: ACT Policing; Crime Operations (including illicit drugs, people smuggling, human trafficking, child sex offences); Counter Terrorism; International Operations; Organised Crime and Cyber; People, Safety and Security; Protection Operations; and Specialist Operations.

A description of the work undertaken by each business area within the AFP is included at *Appendix 3: AFP Business Area Descriptions.*

Workforce overview

According to the 2016/17 Annual Report, as of 30 June 2017, the AFP had 6,540 staff. This is inclusive of 3,383 police officers, 716 protective services officers and 2,441 professional (unsworn) staff. Forty-five per cent of employees were based outside the ACT, including 276 staff overseas and 32 staff serving in Commonwealth external territories (AFP, 2017). The following head count by business area was provided at the time of the Mental Health Review.

Function	Head Count Indicator
ACT Policing	879
Asia-Pacific Group	15
Australian Institute of Police Management	22
Capability Development	41
Chief Counsel	100
Chief Financial Officer	218
Chief of Staff	91
Chief Operating Officer	2
Counter Terrorism	221
Crime Operations	429
International Operations	438
Office of the Commissioner	5
Organised Crime & Cyber	467
People, Safety & Security	302
Protection Operations	1299
Reform, Culture & Standards	103
Special Members	0
Specialist Operations	512
Support Capability	815
Technology & Innovation	230
Workforce & Development	321
Total	**6510**

Review methodology

The following activities were undertaken for the purpose of this review.

1. Literature review

Phoenix Australia undertook a review of the peer review literature on mental health in policing and like organisations to inform the questions to be addressed within the overall review. The literature review examined the prevalence of posttraumatic stress disorder (PTSD) and other mental health disorders in comparable organisations (policing including child exploitation and counterterrorism as well as Defence), and the workplace factors and stressors in these organisations that impact on mental health. A brief summary of the findings is included in *Appendix 4*: *Literature review*.

2. Review of AFP documentation

In advance of consultation meetings, Phoenix Australia requested all available documentation on policies relevant to staff wellbeing that address workplace stressors such as critical incidents, bullying and fatigue, and policies that relate to staff support, as well as any specific policies for staff working in high trauma areas such as child pornography, counter terrorism and overseas deployment. Unfortunately, we did not receive all of these documents before the consultations began but over the course of the review we received and reviewed 60 documents, of which 39 were directly relevant to the documentation review. We grouped these documents into three types: 1) overarching strategic documents; 2) OHS policy documents and guidelines; and 3) Organisational Health Branch documents.

The AFP has a number of high-level overarching strategic documents that collectively provide a comprehensive and well-articulated vision for supporting the mental health and wellbeing of its workforce. However more detailed documents that outline specific plans for the implementation of the mental health strategy are lacking. Similarly, a review of the current OHS policy documents and guidelines reflect a lack of a comprehensive organisation wide approach to managing mental health that would support the operationalisation of the Mental Health Strategy. For example, psychological injury is not explicitly considered in a number of the documents addressing risks and hazards, or in several documents relating to work, health and safety training, and there is no policy guidance for managers in dealing with appointees experiencing mental health issues.

Documentation regarding the governance and role of current support services, and how these integrate and coordinate with each other, is also lacking. Further, there was no evidence of quality assurance processes for the range of current support services.

These detailed policy and procedure documents, along with comprehensive service charters and quality assurance mechanisms for staff support services, need to be in place to support the successful implementation of the AFP Mental Health Strategy.

The findings of the review of AFP documentation were used to inform the recommendations of this review. Detailed commentary on documents that were deemed to be within the scope of the document review is presented in *Appendix 5: Document review,* along with a complete list of the documents received and reviewed.

3. Face-to-face consultations with senior leaders, union and staff support personnel

Phoenix Australia interviewed senior leaders across the organisation, as well as union representatives, to understand their perspectives on general and specific workplace factors that impact on the wellbeing of staff. Views on AFP's current approaches to identifying and managing psychological risks including the accessibility, effectiveness, and barriers to uptake of staff support services, were also explored with senior leaders and union representatives. We also interviewed staff support personnel (e.g., medical, psychology, social work, rehabilitation providers and the employee assistance program (EAP) provider) to gather information on the policies and procedures for staff support, common presenting problems, and intervention approaches (e.g., treatment/referral/quality assurance), as well as their perception of the accessibility, effectiveness, and barriers to uptake of staff support services. The interviews were conducted between 2nd May 2017 and the 9th June 2017. We completed 41 interviews as part of this process, with broad coverage across all functions within the organisation.

4. Staff focus groups

Between the 2nd of May and the 4th of June 2017, Phoenix Australia conducted 36 staff focus groups at multiple AFP locations within Australia covering the key roles of investigations and prevention, community policing, protective services, international police assistance, criminal asset litigation, liaison and partnership, forensics, specialist capabilities (including intel, surveillance, tactical operations, covert) and corporate services. Teleconference focus groups were made available for staff currently serving overseas, although uptake of this opportunity was low. The focus of the groups was to gather staff perspectives on workplace factors that positively or adversely affect their mental health, as well as their views on how those factors could be strengthened or mitigated as appropriate. The groups also explored participants' knowledge of current support services and systems for managing wellbeing, as well as perspectives on the accessibility, effectiveness and barriers to support service uptake. All staff were invited by the AFP to attend groups being hosted in their location, such that anyone in any business area or role could attend (i.e., groups were not organised by business area or role type). AFP staff were invited via email and their attendance was confirmed via an online booking service (Try Booking). The invitation included an information sheet about the purpose of the staff focus groups as well as information about the family teleconferences. The information sheet is included in *Appendix 6: Invitations to attend staff focus groups and family teleconferences*.

Staff focus groups were held in the following locations: multiple sites in Canberra: Edmund Barton Building (EBB), Majura Campus, ACT Policing (Belconnen), and the AFP College; Regional Offices (Adelaide, Brisbane, Melbourne, Perth, Sydney), Airports (Canberra, Darwin, Perth, Sydney, Gold Coast, Cairns, Melbourne, Adelaide), and Protection sites (Geraldton, Pine Gap, Exmouth).

Upon request, we also provided the opportunity for individual staff at any level in the organisation to have a one-on-one interview with a member of the Phoenix Australia review team or to provide a written submission for consideration for the review. We conducted 30 individual staff interviews, and received 36 individual written submissions, which included 32 submissions from AFP staff and four submissions from family members of AFP staff.

Family members of AFP staff were invited (via an email sent to staff) to participate in focus groups designed to gain family members' perspectives on workplace factors that positively or negatively impact AFP staff mental health, as well as how those factors could be strengthened and mitigated as appropriate. Knowledge of current support services and systems for managing wellbeing, and perspectives on the accessibility, effectiveness and barriers to support service uptake were also explored. We acknowledge the limitation inherent in the method of recruitment of family members but direct contact was not possible. Six teleconferences were held with around 3-4 family members per group.

Despite several challenges in the conduct of staff focus groups, specifically, staff being given short notice of the timing and purpose of the groups (which may have limited numbers), and the attendance of managers and supervisors at some groups (potentially inhibiting open discussions), we are confident that the process allowed us to gather information that reflects genuine issues facing AFP staff.

Qualitative evidence from the appointee consultations (i.e., interviews, focus groups, written submissions) was organised into fifteen key themes. Each of these, with a short description is listed below.

1. **Positive aspects of working at the AFP:** Staff highlighted work conditions, relationships with colleagues, work variety and pride in policing work as positive aspects of working for the AFP. They are committed and dedicated to the mission of the AFP.
2. **Perception of change for better:** Staff are hopeful that there is a genuine commitment to change in culture, attitudes and practices relating to appointee mental health and wellbeing.
3. **The pace of change and commitment to sustainability:** Staff expressed concern that changes are often implemented without consultation and too quickly, such that sustainability is difficult to achieve.
4. **Manager capability:** Staff noted that the quality of people management skills is highly varied across the organisation, and that some managers are not sufficiently trained in these areas. Concern was expressed that people are often promoted or rewarded despite lacking these people skills.

5. **Performance management and career development:** Senior leaders, managers and staff all expressed concerns about the effectiveness of current performance management processes. In particular, there were concerns that poor performance is not managed well within the AFP and that managers are not adequately supported when they try to manage poor performers. Links between performance appraisal and career development opportunities are not clear.

6. **Cultural identity:** The AFP is a complex organisation with many different functions and areas. Working out how to create shared identity, whilst acknowledging differences (i.e., geographical, roles, management level, and gender) is an ongoing challenge. Differential treatment of groups within the AFP creates perceived injustices across the organisation.

7. **Managing budgets, resources and demands:** Staff reported feeling a constant pressure to do more with less and that increasing demands were not accompanied by sufficient resources to do the job.

8. **Adequacy of current wellbeing supports:** There were strong perceptions that mental health support services are poorly integrated and under resourced, and that this has worsened in recent years.

9. **Attitudes to mental health reflect stigma:** There were widespread perceptions that it is hard for people to raise their hands if they are concerned about their mental health. Appointees worry about confidentiality, adverse career impacts, and losing composite pay. There is a general perception that management does not promote help-seeking or take action to support the health and wellbeing of staff.

10. **Recovery after psychological injury at work:** Staff were critical of the both the AFP and Comcare in helping appointees with psychological injuries to access appropriate care, manage insurance claims and return to work. The system was perceived as being excessively adversarial.

11. **Mental health training at all levels:** Staff would like to increase their mental health literacy and strongly supported an organisation-wide mental health training program, including training for new recruits. Training managers first was seen as a priority.

12. **Psychological assessment:** There were perceptions that current psychological assessment procedures are bureaucratic, inconsistently applied, and do not reflect a genuine concern for appointee wellbeing. Staff were supportive of increasing wellbeing assessment, commensurate with role and risk of exposure to critical incidents, provided it would lead to meaningful support.

13. **Professional standards complaints processes:** Concern that the complaints process does not ‘triage’ complaints based on severity, such that minor offences can be left unresolved for long periods. Lengthy time delays can leave appointees isolated and without supports during internal investigations.

14. **Availability of clear policies, procedures and guidelines:** There were perceptions that the organisation lacks clear HR and wellbeing policies that would increase fairness and transparency of decision-making in these areas such as promotions, transfers, and determination of psychological fitness for service. Staff lack clarity about what supports they can reasonably expect to receive from the organisation.

15. **Learning from others:** Staff expressed a desire for the AFP to seek guidance from, and collaborate with similar high-risk organisations (state police, ADF) when developing their approach to mental health. More generally, appointees would like to see the organisation foster a learning culture where individuals and teams are allowed to learn

from mistakes in order to grow, develop and improve. Several people mentioned a "culture of fear" when it comes to making mistakes, resulting in excessive caution and an aversion to taking risks.

A full summary of key themes from the staff consultations is presented in *Appendix 7: Key themes from the consultations*.

5. Online survey for all AFP staff

An online survey was conducted to gain a better understanding of the psychological health and wellbeing of AFP staff, as well as the stressors they experience and their perceptions of AFP mental health services. This online survey was made available to all staff between 27th July and 31st August 2017, with 2593 staff taking part in the survey. This represents a response rate of 45%, although only 33% of all staff completed the survey. The complete survey results are presented in *Appendix 8: Staff survey: Method and results.*

With this survey being voluntary and open to all AFP staff, the results cannot be used to estimate the prevalence of mental health problems across the AFP. Those who chose to respond to the survey may have been a biased sample and therefore not representative of all AFP staff. Nevertheless, the results do provide an indication of the extent of mental health problems that may exist within the organisation and will be a point of comparison with future surveys, including the *beyondblue* National Mental Health and Wellbeing of First Responders Prevalence Study currently underway (D. Lawrence (UWA), personal communication, 2017). The key findings were as follows:

- 23% of AFP survey respondents reported moderate to high current psychological distress, with slightly higher rates amongst Unsworn/Professional staff (25%) compared to Sworn staff (21%). The overall average score was 19.4%, which falls into the "likely to be well" category.
- 14% of survey respondents reported symptoms consistent with a diagnosis of depression.
- 6% of survey respondents reported symptoms of clinically significant anxiety.
- 9% of survey respondents reported symptoms consistent with a PTSD diagnosis.
- 9% of survey respondents reported problematic alcohol use.
- The depression measure (PHQ-9) includes a single question related to thoughts of being better off dead or of hurting yourself in some way. Please note that this does not equate to suicidal intent. However, 9% of survey respondents endorsed this question.

Please also note that self-report rates are often higher than rates based on structured clinical interviews and so these rates are likely to overestimate rates of diagnosable mental health disorders.

The purpose and methodology of this study do not permit direct comparisons with mental health prevalence rates in the Australian community (Slade et al., 2009) or even rates in a more comparable work population, the Australian Defence Force (McFarlane et al., 2011). The key differences lie in the AFP survey being an open invitation to staff rather than a

selected representative sample, based on self-report rather than structured diagnostic interview, measuring current symptoms rather than symptoms in the past 12 months, and being conducted many years later.

Nevertheless, as a point of reference, the 12-month prevalence of mental health disorders reported in the Australian Defence Force (ADF), and a community sample matched to the ADF for age, gender and employment status (McFarlane et al., 2011) are as follows: affective disorder (including depression), 9.5% in the ADF and 5.9% in the matched community sample; PTSD, 8.3% in the ADF and 5.2% in the matched community sample; anxiety disorder, 14.8% in the ADF and 12.6% in the matched community sample; and alcohol use disorder, 5.2% in the ADF and 8.3% in the matched community sample.

6. Final report

The information gathered during the course of the review was collated and the review team met to consider recommendations for improvement. Consideration was given to a range of options including completely outsourcing mental health support but it was considered that the greatest benefit would be derived by building up the range of existing supports, internal as well as external, to create a comprehensive, coordinated stepped care model. In addition to best meeting the needs of individuals, the stepped care model represents the best value for money. The more that is invested at lower levels, the more human and financial cost will be saved at higher levels. Resources put into Level I (interventions for all staff), such as creating a supportive, mental health aware environment and building self-care skills, will help to prevent the development and/or escalation of mental health issues. Resources allocated to Level II (for staff with early or mild mental health concerns), targeting early intervention with emerging problems, will help prevent the development of diagnosable mental health conditions. Finally, resources allocated to Level III (for staff with diagnosable mental health conditions) will help to reduce the severity and length of disorder (possibly eliminating the need for a formal Workcover claim in some cases).

The review team's recommendations address the shortcomings identified through the review and are consistent with the best practice principles articulated in Phoenix Australia's framework for managing mental health in high-risk organisations. These principles are explained in the following section.

Considerations for managing mental health in high-risk organisations

There are unique considerations in the delivery of mental health and wellbeing services for high-risk organisations like the AFP.

These include:

- **Whole-of-organisation approach**. The diverse needs of all staff across the organisation must be addressed, taking into consideration variable risk of exposure to operational stressors and trauma, different physical and psychological fitness requirements according to role, and, where applicable, access to different support systems (i.e. uniformed versus non-uniformed staff).
- Mental health and wellbeing initiatives must be integrated with health, welfare, personnel management, OH&S and training policies and procedures.
- Team and leadership cultures have a direct impact on job satisfaction and overall staff wellbeing, which in turn, can influence mental health outcomes, including following traumatic incidents.
- High-risk organisations have a duty of care to ensure that recruitment, training and preparation, mental health screening and surveillance systems, and mental health services are responsive to organisational stress and both critical incidents and the longer-term impacts of cumulative stress.
- **Operational fitness**. Some staff are required to maintain high levels of readiness and training to ensure they can conduct their duties in a safe and effective manner. Many will have access to service firearms. This level of operational fitness requires psychological readiness and resilience. Unrecognised mental health issues can affect decision-making and capacity to cope in high pressure situations.
- There is an interaction between organisational stress and the potential impact of traumatic events. High-risk roles often place additional demands on individuals and teams (e.g. intensive training to maintain knowledge and skills, shift work) that can increase stress and impact on a person's capacity to cope with critical incidents.
- **Cumulative trauma**. There can be a cumulative impact of exposure to lifetime traumatic experiences, and for some individuals there will be a progressive increase of symptoms with repeated trauma exposures, with those with sub-syndromal posttraumatic stress at risk of delayed onset PTSD. For some, the most distressing and stressful event will occur early in their career.
- **Recruitment and selection**. A good fit between a person and their job and a sense of control and competency can improve job satisfaction and wellbeing at work.
- A number of risk factors are associated with being adversely affected by exposure to critical incidents (e.g. poor current psychological wellbeing, previous mental health issues). These risk factors are not sufficiently reliable to use as selection criteria in isolation as some individuals can carry all of these risk factors but still be resilient in the

face of trauma, while others, without any of these risk characteristics, can be vulnerable. However, in high-risk roles where repeated trauma exposure is likely, consideration should be given to including assessment of trauma history and any indications of a lack of ability to cope effectively with adverse events.

- **Preparedness**. Increasingly, workplaces with high-risk operational environments are taking an approach to critical incident / trauma exposure preparedness from recruitment onwards. This includes on-going training and monitoring throughout a person's career, and resilience training.
- **Resilience**. Resilience is an emerging field of research and there is yet to be solid evidence about the type and extent of training required to help mitigate the impact of exposure to traumatic events. However, ensuring that staff are at a minimum trained in mental health literacy can improve identification of problems early and encourage help seeking, and best evidence supports interventions that teach active skills rather than just providing education. The emphasis of this training should be on building and maintaining high performance in individuals and teams, rather than just on the management of trauma exposure.
- **Stigmas and barriers to care**. Various factors contribute to the under-utilisation of mental health services within high-risk populations, including cultural values of self-sufficiency, masculine identity, concerns they will be treated differently, and the requirement for good occupational health. Attempts to reduce stigma as a barrier to care should target these contributing factors.
- There is a tendency amongst many staff in high-risk organisations to minimise problems and not access services. For this reason, monitoring mental health without promoting its importance through education and management practices is likely to be ineffective.
- Staff and managers require mental health literacy training, with managers receiving additional information about monitoring and supporting staff mental health.
- As families are often the first to notice changes in someone's mental health, they also need the necessary knowledge and skills to provide support, and facilitate appropriate help seeking.
- There should be options for an individual to be able to assess and monitor their own mental health and resources to support self-help and guide appropriate help seeking.
- **Mental health screening**. Psychological screening should be part of a comprehensive model of support that includes a workforce that is mental health literate, has processes for monitoring wellbeing after critical incidents, and has access to support services commensurate with need. The frequency and nature of psychological screening should be risk indicated.
- **Mental health services**. There should be a range of informal and formal mental health support systems, with clearly defined roles and mandates for each component of the service system. This facilitates being able to match the needs of the individual with the most suitable form of assistance.

- The organisation should seek to ensure staff with mental health problems are provided with evidenced-based treatment. This will provide them with the best opportunity for recovery and positive return to work outcomes. Internal psychology services can be well placed to provide organisational support, assessments and interventions as they understand the unique requirements and stressors of the occupation. This includes the conduct of fitness for duty assessments which consider factors such as access to service firearms and the individual's ability to safely conduct high-risk roles/tasks. As there can be a tension between help seeking and concerns about career progression, there needs to be a clear delineation between organisational roles and clinical roles for internal psychology services, and this needs to be supported by adequate resourcing.
- If clinical services are out-sourced, the organisation still requires internal services to support triage, referral, clinical governance and oversight of external service delivery, case management, and rehabilitation and return to work coordination.
- A balance of internal and external clinical services ensures the ability to cater for staff preferences and allows for services to be either scaled up or down depending on the local context and need.
- **Transition**. Transition out of a high-risk organisation can be a period of significant change, including to identity, community and residence, social networks and status, family roles, occupation, finances, routines, responsibilities, supports and culture. Emerging research highlights the longer term mental health risks for some individuals after they have left high-risk organisations.
- Transition considerations include appropriate acknowledgment of service, links into new support networks, support for employment seeking, and options for encouraging help seeking as required in the future.

The implications for AFP's approach to managing the mental health needs of its staff are as follows. Firstly, AFP mental health services need to be considered in the context of organisational factors, leadership (managers and senior leaders) and the policy framework. Secondly, services should be provided across a continuum from preventative interventions for all staff (Level I), brief interventions for staff with early or mild signs of mental health concern (Level II), to evidence-based treatment for staff with mental health disorder (Level III). Of course the way in which these services are delivered needs to take into account important contextual factors such as the person's role and location, with particular consideration given to issues of risk for AFP staff who have access to firearms. Thirdly, there should be ongoing monitoring of staff wellbeing commensurate with the level of exposure to psychological hazards in their role and their past wellbeing. Fourthly, families are an important element in the resilience of AFP staff and should be engaged in education and support initiatives. Fifthly, separation from the AFP can be challenging and the AFP should take an active role in supporting successful transition. Each of these elements is reflected in a best practice approach to managing mental health in high-risk organisations, illustrated in Figure 1 below.

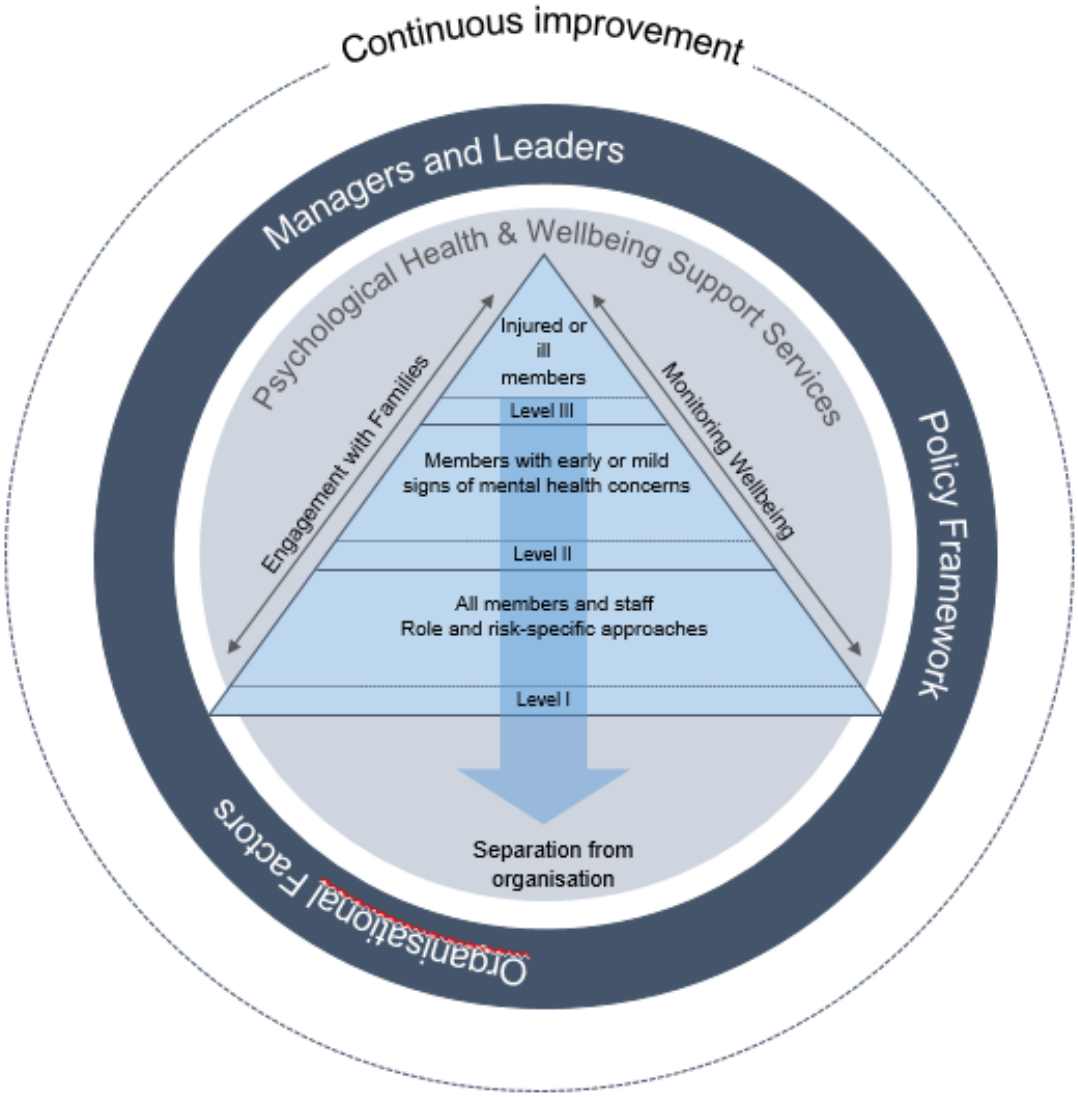


Figure 1: Best practice framework for managing mental health in high-risk organisations

Each element of the model has a number of criteria for best practice against which services can be benchmarked. In the following sections of the report, we present the information gathered through the review of AFP documentation, consultations and survey, as it pertains to each element of the best practice framework model. Importantly, we are particularly attentive to the specific nature, role and function of the AFP when considering the alignment of the organisation with these core elements. On this basis, we provide a series of ratings, which benchmark current practice within the AFP against best practice, and, following from that, recommendations for improvement. Concurrent with this review, the AFP is developing a number of related initiatives, such as preparations to roll out mental health first aid training to leaders within the organisation. We acknowledge that the information contained herein may not include all such initiatives planned or underway.

Benchmarking AFP against the best practice framework model

1. Organisational factors

As noted previously, it is important to recognise the fundamental importance of good organisational practices in promoting mental health in the workplace. A summary of the key research in this area has been included in *Appendix 4: Literature Review.*

In this section we present the findings of the review in relation to organisational factors impacting on staff wellbeing for the AFP's consideration. Recommendations for organisational change at this level are beyond the scope of this report. However, the review team wishes to highlight that a failure to address these issues will undermine any attempts to improve wellbeing and it is highly unlikely that the initiatives discussed later in this report will be effective if the underlying organisational issues are not addressed.

These issues are probably best dealt with by internal or external specialists in organisational structure and practice. We also note that there are several useful guides available to assist in addressing these issues:

- Australian Public Service Commission and Comcare (2013) Working Together: A mental health guide for APS managers.
- Health and Safety Executive (2007) Managing the Causes of Work-Related Stress: A Step-by-Step Approach Using the Management Standards. (ISBN 978 0 7176 6273 9)
- BSI PAS 1010 (2011) Guidance on the Management of Psychosocial Risks in the Workplace. (ISBN 978 0 580 69839 2)

We have organised the findings of our review under key criteria for best practice in the Organisational Factors element of Phoenix Australia's framework.

Criterion 1.1 The organisational mission and strategic priorities are clearly articulated

Evidence from the review

We noted a high level of commitment to the organisation, with most staff saying they were proud to be part of the AFP and proud of the work done by the organisation. Many people, however, felt that there was no shared vision across the organisation of what the AFP was trying to achieve and no agreement on priorities. Rather, it felt like multiple organisations often pulling in different directions.

Rating

Not at all met		Partially met		Entirely met
1	2	3	**4**	5

Criterion 1.2 Organisational values are well defined, operationalised, and built into KPIs for annual performance reviews for staff at all levels of the organisation

Evidence from the review

We noted that the AFP values of integrity, commitment, excellence, accountability, fairness, trust and respect are displayed widely throughout National Office and, to a lesser extent, in regional and remote areas. Additionally, these values are articulated in the *AFP Leadership Philosophy*. While that document provides a blueprint for what is expected of AFP staff in leadership roles, there is no direct reference to policies and procedures that might help to operationalise the capabilities and it is unclear how staff may be held accountable to them. From the staff focus groups, there was a common perception that these values are not reflected in the day-to-day operation of the organisation and are merely "window dressing". It was felt by many that staff at all levels should be held accountable to these values through KPIs in their annual reviews.

Rating

Not at all met		Partially met		Entirely met
1	2	**3**	4	5

Criterion 1.3 All supervisors/managers/executive have a thorough knowledge of HR policies and procedures, with particular reference to those that impact on psychological health and wellbeing (e.g., bullying, professional standards)

Evidence from the review

We note that there are a large number of policies and procedures within the AFP and it is not easy for anyone to know all of them thoroughly. Nevertheless, we received consistent feedback that some supervisors and managers had little or no idea of the content of many AFP policies (or, if they did, chose to ignore them). Staff in both focus groups and the SES indicated that some HR policies and procedures, particularly those regarding mobility, lacked transparency:

"Senior execs are expected to move, but a lot of people don't end up going…The culture around mobility is confused." (SES Staff member).

This suggests that HR policies are implemented inconsistently, and lack of manager training and/or accountability for consistent implementation appears to be an important contributing factor. Appropriate training in key policies could be a pre-requisite for promotion to a supervisory/managerial position, with accountability for their appropriate implementation a component of performance reviews.

Rating

Not at all met		Partially met		Entirely met
1	2	**3**	**4**	5

Criterion 1.4 In order to ensure perceptions of organisational justice and fairness, clear policies exist around pathways for career progression across the staff lifecycle, including a high level of transparency in promotions, postings, annual performance reviews, and professional development opportunities

Evidence from the review

It was our impression that the organisation is aware of concerns, and is taking steps to improve, transparency and ensure fairness in promotions, postings, and other career development opportunities. We strongly commend these initiatives but recognise that problems still exist in some areas. We certainly support continuing down this path towards greater transparency and perceived fairness. It is worth noting that a consistent theme in the focus groups was cynicism about the performance development appraisal (PDA) system, with staff believing that the process was not helpful for career development or performance management. For many staff, the outcome of a PDA did not appear to be linked to recognition or reward for good performance.

Rating

Not at all met		Partially met		Entirely met
1	2	3	**4**	5

Criterion 1.5 Selection processes and polices are clear and transparent, with a view to ensuring selection of the right person for the right job, including suitability for high-risk roles; appropriate training is provided (including people management skills, leadership skills, mental health literacy, etc.)

Evidence from the review

This issue is an extension of the previous item. Although we understand that there are well established selection processes, including suitability for high-risk roles, feedback from the focus groups reflects a perception that people are often placed in positions for which they are not entirely suitable and/or are not appropriately trained. Concern was raised that such appointments not only create a psychological risk for the staff but also for colleagues.

Rating

Not at all met		Partially met		Entirely met
1	2	3	**4**	5

Criterion 1.6 Demonstrated attention to the common causes of occupational stress are included as KPI's for middle and senior level managers:

1.6.1 Demands (e.g., adequate resources are available; excessive demands on individual staff are carefully monitored and addressed as soon as possible; staff skills are matched to job demands)

1.6.2 Control (e.g., staff have opportunities to be involved in decision making; as far as possible, work type/load/timing is negotiated; training is provided where required)

1.6.3 Support (e.g., a culture of mutual support exists within the team/section; managers are seen as supportive; staff are aware of other support services)

1.6.4 Relationships (e.g., conflict is dealt with promptly and openly with a view to resolution; unacceptable behaviour is managed quickly and actively)

1.6.5 Role clarity (e.g., position descriptions are accurate; performance appraisals address the person's "fit" with the role demands)

1.6.6 Change management (e.g., change is clearly communicated at all stages; consultation occurs where possible; impacts on jobs are clarified and addressed)

Evidence from the review

Demands

One of the most consistent concerns expressed in most (albeit not all) areas of the organisation related to a perceived shortage of resources combined with excessive demands. There were widespread perceptions that budgets are constantly cut, with no associated cuts in what is expected, and that the organisation accepts increasing demands from government without extracting the additional resources required to meet those demands.

"They want more for less." "[There is] a never-ending cycle of demands." (ACT Policing).

A similar sentiment was expressed by SES level staff:

"We need to decide what is our core business and do it well." (SES).

There was a feeling that resources are not allocated according to need, with a perception among the regions that National Office is over-staffed. It was suggested that larger regions (especially NSW and VIC) need more resources (it was argued that 75% of AFP "work" in the form of drug seizures, organised crime, terrorism, etc. is done in Sydney and that members are extremely overworked). It was suggested that the State Manager in those states should be A/C level (adopting a similar model to the FBI).

The three most often cited operational stressors in the survey ("finding time to stay in good physical condition", "paperwork", and "fatigue"), as well as two of the three most cited organisational stressors ("staff shortages" and "bureaucratic red tape") all related to the perception of excessive demands.

Control

These perceptions of excessive demands feed directly into feelings of lack of control over one's work. Some people reported having to work long hours just to get work done. In some cases, for example in cyberterrorism, staff noted that leaving before the work is done is simply not an option due to the critical nature of the work. This responsibility seems to be borne at the individual rather than organisational level. Other areas complained of working with staff levels that are too low to be safe for operations and contrary to OH&S guidelines.

"The job comes first…We've got to get the job done", (Staff member, NSW).

Some complained of a "culture of fear" around the risk of making mistakes, noting that responsibility is a heavy load when resources are insufficient.

A sense of control over one's own career progression was also reportedly undermined by perceptions that organisational processes such as promotions and postings are not done in a fair and transparent way. There was a widespread perception that it was "not what you know, but who you know" that determines your career progression. Indeed, the second most commonly cited organisational stressor in the survey was "the feeling that different rules apply to different people (e.g., favouritism)". Again, this feeds into a sense of lack of control.

Support

There was considerable variation in perceptions regarding the quantity and quality of support provided by line managers and colleagues. Many reported gaining good support from these informal networks although it was highly variable, depending a great deal on the leadership and "people skills" of the supervisors and managers in any given team. Shift workers, as well as those whose rosters were flexible and promulgated at short notice, generally reported more difficulty in accessing both informal and formal support. Others were critical of an overall perceived lack of support, including lack of acknowledgement of their work and the levels of risk to which they were exposed. A general lack of support was noted particularly for overseas personnel and their families.

It was clear that many middle managers felt unsupported, especially when dealing with poor performance of their staff or other people management issues. Some suggested that all the support is directed towards the staff member (perhaps through an organisational fear of bullying accusations) with little or no support for the manager. It was felt by some that requests for help (e.g., from welfare and Psychological Support Services to deal with a staff member who has mental health issues) are ignored or result in criticism (e.g., being called a "dinosaur").

Relationships

As with support, there were clearly teams within the organisation that function very well and in which conflict is rare. Equally, a common theme was that, although there are some very good managers at all levels of the organisation, there are also many who do not have strong leadership and people management skills. Some staff felt that this results in strained workplace relations with conflict, unacceptable behaviour, and poor performance being allowed to continue without appropriate management intervention. It was felt that competent managers with good skills in managing issues within the team need to be supported to allow them to become champions for cultural change and that more training and mentoring in areas such as leadership and people management is required for personnel going into supervisor and management positions.

Role

Although not explicitly described in terms of role clarity, it was clear that the perceived excessive demands on some staff, combined with low resources, often challenged the boundaries of their positions. Some felt that they were often required to carry responsibilities beyond those for which they had been appointed and that job descriptions were out of date and no longer accurately described their role. This pressure to "do more with less" was particularly apparent for surge and transition activities.

There was widespread concern that this role blurring is exacerbated by the organisation's unwillingness to manage poor performance, including a perception that difficult staff are often just moved to another area ("packaged for export"). Some staff felt they needed to step outside their role in order to cover for poorly performing colleagues and get the work done. It was felt that the performance development appraisal (PDA) system is often not taken seriously and is not effective in managing poor performance or in recognising good performance. Rather, it is seen purely as "ticking the box for HR".

"The PDA process breeds mediocrity." (Staff member, NSW).

Change

There was a widespread recognition that the organisation is undergoing a period of considerable cultural change. While this was welcomed in principle, concern was expressed about the pace of change, the adequacy of communication to staff about the changes, and the organisational commitment to sustainability. Some people felt that too much was happening too quickly, with many new initiatives coming across people's desks in rapid succession (e.g., cultural reform, future directions, mental health). There was concern that these initiatives are not necessarily part of a clearly thought through strategic process but, rather, were a rapid reaction driven primarily by the need to be "seen to be doing something" in response to a crisis. Indeed, several people described the AFP as a "reactive organisation". It was felt by some that the desire for rapid change without necessarily engaging the whole workforce will lead to multiple independent initiatives that are not sufficiently integrated.

There was some concern that a failure to manage this change properly and at an appropriate pace will jeopardise its chances of success. For example, people talked about the need to "stop the gender panic", arguing that in the wake of the Broderick Review there is a risk of generating resentment and opposition in men who perceive that they will be refused promotion in favour of women, as well as concern among women that they are being promoted (or perceived to be promoted) because of gender rather than merit. The importance of this, and relevance to the Mental Health Review, is the link between organisational change and staff wellbeing.

Culture

Some concern (and cynicism) was expressed regarding the extent to which the organisation was actually committed to the AFP values. It was felt that personnel at all levels of the organisation need to be explicitly held to account with regard to these values.

Much was said about the organisational culture of the AFP, with many comments to the effect that it was a divided organisation. It was recognised that this is, in part, the "nature of the beast" – indeed, some described it as a "platypus", with widely different organisations being forced together into an unnatural whole. We certainly detected many examples of hostility and resentment between various sections such as: geographically (e.g., Canberra vs regions vs remote locations); work roles (e.g., National Office roles vs ACT police vs protective services vs aviation); type of staff (e.g., "true blue" AFP vs "laterals" from state police vs ex-PSO's vs current PSO's, as well as Sworn vs Unsworn/Professional staff). Issues of equity and fairness can impact on staff wellbeing and there were suggestions by some of a "growing chasm" between senior management and the rest of the workforce. Staff commented that this has not been helped by the perception that the executive EBA was resolved very quickly while the staff EBA has been outstanding for an extended period of time.

We understood these tensions as illustrations of the very real challenges faced by the AFP in 1) creating a shared cultural identity that is truly respectful of the needs of diverse groups within this complex organisation, and 2) developing systems and processes that ensure appropriate boundaries between groups are respected. We do not underestimate the difficulties of resolving these issues and creating a "united" organisation from its disparate parts. To the extent that it is possible, however, progress in this area to create a more cohesive and united organisation will provide a much more solid base upon which to build improved mental health and wellbeing.

The psychological health of the team or section should be a high priority for any manager. We know that some managers have great skills in this area and that this is reflected in the morale, cohesion, mutual support and productivity of their sections. Many others, however, either lack the knowledge/skills or see it as a low priority. There is no indication in policy documentation that mitigating these sources of stress is considered to be a part of managers' role or responsibility.

Rating

Not at all met		Partially met		Entirely met
1	2	3	**4**	5

Conclusions

We cannot overstate the importance of good organisational practices in influencing mental health. We can add layer upon layer of mental health support but if the underlying work

conditions in domains such as excessive demands, lack of control, and high levels of conflict are not addressed these measures will be of little use.

We do not underestimate the difficulty of making some of these changes in the current economic climate and in the face of increasing demands from government. It is our opinion, however, that the mental health of AFP staff will always be compromised if the organisational issues are not adequately addressed.

2. Mental health policy framework

We have organised the findings of our review under key criteria for best practice in the Mental Health Policy Framework element of Phoenix Australia's framework.

Criterion 2.1 Mental health policies and procedures are widely available that:

2.1.1 Are evidence informed, reflect a stepped care approach and clarify the roles of and relationships between internal and external health, welfare, and rehabilitation resources

2.1.2 Include clear strategies for dissemination of policies

2.1.3 Include clear protocols for management of exposure to critical incidents, including cumulative exposure

2.1.4 Include a data management component to allow for both care co-ordination and data analysis at both individual and organisational levels (i.e., e-records, de-identified databases)

2.1.5 Include an evaluation framework for policy implementation

2.1.6 Are systematically reviewed every 5 years, along with related policies (such as bullying and professional standards), to ensure coherent integration and effective implementation across all areas of the organisation

Evidence from the review

The draft *Mental Health Framework* is a well-written, high-level document, based on current best practice guidelines, strategic planning documents and policy documents prepared by national and international agencies that are leaders in the field of organisational mental health and wellbeing. It provides an overview of the current mental health needs of the AFP by analysing Comcare data and utilisation of EAP and Psychological Support Services. *The Mental Health Strategic Action Plan* describes a number of initiatives that will be undertaken to achieve the objectives and goals of the framework. It describes the scope of interventions as covering promotion, prevention, early intervention and tertiary prevention but does not detail what the exact interventions will be. Timeframes and costs are incomplete and there are no detailed implementation plans.

The following comments benchmark AFPs current mental health policies and procedures against the best practice framework.

In reference to 2.1.1 above, there is no detail on interventions to be provided at each level and no clarity on the roles of and relationships between Organisational Health Branches (i.e., Medical Services, Psychological Support Services, and Work Health and Safety Rehabilitation (WHSR) or external providers. With respect to 2.1.2 there is no clear strategy for dissemination. The *Mental Health Strategic Action Plan* makes reference to promotional methods to increase awareness of mental health issues and access to quality information about mental health (i.e., Level I strategies) but does not explicitly refer to dissemination of mental health policy or training of managers in how to implement policy. Feedback from staff

within the Organisational Health Branch indicated that managers are often required to act without clear policy, suggesting both a lack of policy and poor dissemination.

"Big disconnect [with respect to] human resources, lack a huge amount of policy and procedure (e.g. fitness for continued duty). Means managers are doing policy on top of their existing role, taking on a lot of HR stuff…. No policy, procedure, training to help guide managers in dealing with staff wellbeing." (Staff within Organisational Health).

In reference to 2.1.3, the *National Guideline on Critical Incidents* outlines an appropriate procedure to follow, including for staff wellbeing, in the event of a critical incident. However, consultations with staff suggests a low level of awareness of this Guideline and the extent to which it is implemented as intended is not clear. Furthermore, there is no consideration of cumulative exposure for staff in high-risk roles in the Guideline. The only work area that seemed to have a specific policy on this was for the viewing of objectionable materials. We were pleased to note that reference was made to developing protocols for managing critical incident exposure in the *Mental Health Strategic Action Plan,* which will hopefully include consideration of cumulative exposure in a range of high-risk roles.

With respect to data management (2.1.4), we note that the *Mental Health Strategic Action Plan* identifies the need to strengthen information systems across the health portfolio. We agree that this is currently a shortcoming, as reflected in comments from staff in the Organisational Health Branch that there is a lack of systems to support health record management (i.e., e-health records, medical record databases able to be shared across AFP health service providers). Current systems fail to adequately support care coordination across multiple service providers or allow for auditing/data analysis. Further, the poorly integrated paper based medical records system does not enable Organisational Health Branches to respond quickly to operational demands (i.e., rapid personnel selection for deployment) or maintain efficient oversight of organisational responsibilities (i.e., ensure routine monitoring of staff health).

With respect to the final criteria (2.1.5 and 2.1.6), the *Mental Health Framework* indicates that an Organisational Health Working Group will be established to guide the delivery of the *Mental Health Action Plan*, with progress to be reviewed annually. Review of the *Mental Health Framework* is scheduled for 2019; however, no information is provided about how this review will be done, nor how it will be integrated with revisions to related organisational policies that have clear links to wellbeing (e.g., bullying, professional standards, and recruitment). Many staff in the focus groups raised concerns over the mental health impacts of the Professional Standards (PRS) process, highlighting the need for the Organisational Health Branch to be involved in revisions to these policies.

"I was treated like a criminal…it was the most stressful experience I've ever been under" (Staff member referring to being investigated by PRS, VIC).

In summary, the AFP is to be commended for its *Mental Health Framework* and *Strategic Action Plan* but considerable work is needed to translate the intention of these documents into detailed activities that are tailored to the AFP context, and systematically implemented and evaluated.

Rating

Not at all met		Partially met		Entirely met
1	2	3	**4**	5

Criterion 2.2 Clear business plans, strategy documents and policy and procedure documents are in place for each element of the staff support services, with the structure clearly defined and agreed

Evidence from the review

Two policy documents relating to the Work Health and Safety Rehabilitation Division (WHSR) spell out a service charter for the Division including service standards, values and KPI's for three areas of WHSR (i.e., Work Health Safety, Rehabilitation, and Compliance). There were no other policy or procedure documents accompanying the business plan that indicate how the WHSR strategy is operationalised in the workplace and no evaluation report indicating performance against KPI's were provided.

There were no documents that describe the charter or business strategy for the Medical Services teams or Psychological Support Services. As such, there is no information on the role, model of care, referral and access arrangements, governance and accountability framework for these staff support services. The *Mental Health Framework* document does provide an indication of the types of services that Psychological Support Services offer by giving a snapshot of the pattern of usage of their services in 2014-15.

Rating

Not at all met		Partially met		Entirely met
1	2	3	**4**	5

Criterion 2.3 OH&S risk assessment and risk management policies and procedures include attention to mental health and wellbeing issues

Evidence from the review

A detailed review of each document is provided in *Appendix 5: Document Review,* in the section on *Specific OHS Policy documents and Guidelines*. In summary, policy and guideline documents that outline what is currently in place to manage psychological risk in general and trauma exposure specifically, are limited or under development. Mental health injury to AFP personnel is rated as high (likely to happen and with major consequences) in the Enterprise Risk Profile Executive Summary. The treatment plan for this item identifies five treatments which are self-rated as being on track for completion, although no specific KPIs were

identified. The treatment plan included resourcing to meet mental health first aid and suicide prevention training needs, cultural change review action items, increased Organisational Health involvement in leadership development and health monitoring (this one is rated as progressing but behind schedule).

With the exception of a policy on the viewing of child exploitation material, there were no documents provided that detail the specific psychological risks associated with different work areas or risk management plans to address these. Furthermore, there was no evidence of how critical incidents involving psychological injury are currently responded to at a regional and business area level, and how and when psychological services might be activated to support staff involved.

A hazard register listing 648 incidents that occurred between 2008 and 2017 across the AFP, included only a small number of incidents that would constitute a psychological hazard. This may represent only those hazards that are outside of what staff expect to be exposed to in the course of their work and if this is the case, under-represents the true level of exposure to psychological hazards.

Rating

Not at all met		Partially met		Entirely met
1	2	3	**4**	5

Recommendations

We offer the following recommendations for improvement in relation to the Mental Health Policy Framework.

RECOMMENDATION 1 Build on the current mental health strategic plan to develop a comprehensive framework for the evaluation of mental health policy implementation that: a) identifies the gaps in existing policy documentation; b) delineates a plan for the development of the necessary policy documents; c) addresses how the policy is to be disseminated across the organisation; d) outlines what training and support is to be provided to staff who have responsibility for implementing components of the policy; e) details the intended impacts of the policy; and f) explains how these will be measured.

RECOMMENDATION 2 Develop a policy and procedure document that outlines: a) the role of each component of staff support services; b) the relationships between each component, reflecting a stepped care approach; c) referral and access pathways;d) confidentiality and privacy considerations; e) governance arrangements; and f) quality assurance mechanisms. (Note: a recommended framework for stepped care is elaborated in Section 4 below).

RECOMMENDATION 3 Introduce an electronic health record that can be shared across each component of staff support services.

3. Managers and leaders

We have organised the findings of our review under key criteria for best practice in the Managers and Leaders element of Phoenix Australia's framework.

Criterion 3.1 Senior leadership regularly communicates with all staff regarding importance of mental health and promoting help seeking

Evidence from the review

Interviews with staff at all levels indicated strong and wide-spread support for the current Commissioner's focus on mental health. Commissioner Colvin's initiatives are broadly seen as genuine. A number of comments were made in the focus groups about the impact of Commander Grant Edwards' speaking publicly about his personal experience of PTSD. Many saw it as a positive initiative that would reduce stigma, although there was also a more cynical view from some that as a member of the SES, support may be more forthcoming than for 'ordinary' team staff.

"His support base is iron-clad, he was entirely safe to do this." (Staff member, QLD).

There was also concern that positive momentum behind the initiative would be lost.

"The impact of Commander Edwards has been positive, it was an important event, but what do we do now?" (Staff member, ACT).

This concern was mirrored in a broader concern that the organisation will find it very difficult to create sustainable initiatives that are not just "knee-jerk reactions". Comment was made in a number of the focus groups that messages from leadership regarding mental health are not currently embedded in credible and sustainable policies and practices that would demonstrate genuine organisational commitment to improving mental health for staff. Staff were cautiously optimistic that recent communications from senior leadership, particularly the Commissioner, regarding mental health would lead to positive change. There were reservations however about whether middle management were on board with or capable of implementing this commitment. There was also concern that the intent may not be met with sufficient organisational commitment, including provision of adequate resources and supports to enable sustainable change.

The survey included a specific measure of perceptions of leadership commitment to psychosocial safety, the Psychosocial Safety Climate survey (Hall, Dollard, & Coward, 2010). Scores on this measure have been found to be related to risk of job strain (high demands and low control) and poor mental health outcomes. Seventy percent (n = 1726) of survey respondents fell in the high-risk range for depression and job strain on this measure and the overall average score at the AFP fell into the high-risk range. This finding suggests that despite the strong message from the Commissioner that mental health is a priority issue, this has not yet influenced staff perceptions of how much their wellbeing is valued by senior

leaders. For more detailed results on the psychosocial climate survey see *Appendix 8: Staff survey: Method and* results.

In summary, the communication from senior management is well received but it appears that staff are yet to experience tangible changes in the way mental health is prioritised and managed.

Rating

Not at all met		Partially met		Entirely met
1	2	**3**	4	5

Criterion 3.2 All supervisors/managers undergo compulsory leadership training

Evidence from the review

It was our impression that there is considerable variation in the amount of training that supervisors and managers receive in areas such as leadership and "people management" skills.

"We haven't valued leadership training." (Staff member, VIC).

Consultations repeatedly identified a lack of people management skills and training requirements for managers as a central concern. There was a strong perception that people are promoted based on technical ability (or "who you know") and people skills are not considered. There was a widespread view that people should have training and demonstrable expertise in these areas before they are allowed to apply for a supervisory or management position.

Consultations with SES staff indicated that leadership development programs were being developed and should become available to managers soon. Further, we were advised that Workforce Development has recently engaged the Australian Institute of Policing Management for management training, which includes a focus on wellbeing, and an external organisational psychologist to further develop programs. While these initiatives are to be commended, we note that available programs are largely self-directed and are not compulsory for promotion or during the transition from team member level to manager role.

We acknowledge that progress is being made in the area of leadership training for managers and would encourage continued efforts in this domain.

Rating

Not at all met		Partially met		Entirely met
1	2	3	**4**	5

Criterion 3.3 All supervisors/managers undergo mental health and PFA training on a regular basis to maintain currency (i.e., 2 – 3 yearly)

Evidence from the review

There was no evidence from consultations or policy documentation that managers are currently required to undergo any kind of mental health and/or psychological first aid (PFA) training. A small number of managers in the consultations indicated that they had undertaken some form of mental health training, but the choice to do this was self-directed and not necessarily sponsored by the AFP. Feedback from focus groups was highly positive about initiatives to support all managers across both Sworn and Unsworn/Professional roles to undertake mental health training. It was pleasing to hear from senior staff in Workforce Development that there was a plan to roll out mental health first aid training to leaders within the organisation, with a tender currently in preparation.

Rating

Not at all met		Partially met		Entirely met
1	2	3	**4**	5

Criterion 3.4 supervisors/managers are trained in recognising early signs of psychological ill-health, as well as how and when to facilitate referral for assessment and triage of staff with suspected mental health problems

Evidence from the review

Staff in the focus groups acknowledged the critical importance of their relationships with immediate managers in being able to get support for mental health problems and commented that manager capability varied widely with regard to mental health literacy, early identification and referral.

"The support you get will depend on the team leader." (Staff member, NSW).

This was reinforced in the survey where only one-third of respondents said that it was 'likely' or 'very likely' they would approach their manager if they were experiencing concerns about work stress or wellbeing. The rate was even lower amongst those who were currently experiencing high levels of psychological distress, with only 15% reporting that they would seek support from their manager. These findings suggest that managers are not typically or consistently viewed as people to approach for assistance with work stress and wellbeing.

Manager's lack of training and competence in identifying and supporting staff who are experiencing mental health issues may be an important barrier to help-seeking. Commentary from injured workers and staff focus groups suggest that barriers to seeking help from within the organisation, including approaching one's manager, involve concerns about impact on career progression and lack of confidentiality following disclosure. These concerns were rated in the survey as the top two most likely reasons staff would not seek assistance, a pattern that was consistent across Sworn, Unsworn/Professional and PSO staff.

There appeared to be no policies to guide managers in when or how to make referrals for mental health assessment, or to support managers in determining whether a Sworn member is required to be removed from police duties (i.e., accoutrements removed, lose composite pay). Some staff felt that, as soon as there is a suggestion of psychological issues, they lose their accoutrements. Consistent with this, SES staff acknowledged not being aware of policies or practices that support managers to help their team get support. Not surprisingly, comments from team leaders who had supported staff with mental health issues indicated that they did not feel appropriately trained or supported by the AFP to manage these staff. In particular, managers acknowledged that the lack of clarity about the relationship between mental health problems, security clearance and the removal of accoutrements (and composite pay) was a source of worry and they were often uncertain of their role in this process, particularly how to effectively manage tensions between reporting and supporting staff. When combined with poor mental health literacy, this lack of guidance appears to have led to inconsistent outcomes and increased fear among staff about reporting mental health difficulties to managers. While we understand the difficulties here, this course of action is by no means always necessary or appropriate and simply serves to drive mental health issues further underground.

"If you tell your boss before psych services, then you're more likely to get an overreaction." (Staff member, ACT).

"For security clearance, people aren't going to be honest about wellbeing if it leads to a loss of role." (Staff member, NSW).

Rating

Not at all met		Partially met		Entirely met
1	**2**	3	**4**	5

Recommendations

We offer the following recommendations for improvement in relation to managers and leaders.

RECOMMENDATION 4 To promote help-seeking, communicate to staff that senior leadership views mental health injuries as able to be rehabilitated until proven otherwise, and provide clear guidelines around when and why decisions relating to changes to operational status will be taken.

RECOMMENDATION 5 Develop policy and procedure documents that provide guidance to managers on how to manage mental health concerns in their team, including how to identify mental health issues, make necessary referrals, and make decisions about operational issues such as security clearance and the removal of accoutrements. These documents should specifically address how policy and procedures apply in remote and regional areas.

RECOMMENDATION 6 Include leadership and people management skills as key performance indicators in the position descriptions for all managers in the AFP.

RECOMMENDATION 7 Establish compulsory leadership training as a prerequisite for promotion to all management positions across the AFP. This should be face-to-face training wherever possible.

RECOMMENDATION 8 Ensure that all managers within the AFP undergo mental health and psychological first aid training on a regular (2-3 yearly) basis to maintain currency. After the initial training, refresher training could be conducted online.

4. Psychological health and wellbeing support services

We have organised the findings of our review under key criteria for best practice in the Psychological Health and Wellbeing Support Services element of Phoenix Australia's framework.

Criterion 4.1 A clear structure is available to identify the roles of each level of staff support services, the training and supervision requirements, and the way in which they relate to each other, including:

- **4.1.1 All staff (self-care or "looking after yourself and your mates")**
- **4.1.2 Identified peer supporters (informal psychological support, problem solving and referral advice)**
- **4.1.3 Chaplains (engagement, general and spiritual support, problem solving, referral)**
- **4.1.4 Psychology staff (e.g., supervision of non-mental health professional staff such as peers, welfare officers, chaplains; critical incident responses; recruitment and selection; clinical assessment / triage / referral to external providers (EAP and mental health specialist practitioners); brief 1-6 session interventions; review/QA/contract management of external services; in-house health promotion, etc.)**
- **4.1.5 Rehabilitation officers (relationships with psychology staff; relationships with workplace insurers; liaison with treatment team)**
- **4.1.6 EAP external providers (short term – up to 6 sessions – treatment of sub-clinical or mild mental health diagnoses, dealing with psychosocial stressors)**
- **4.1.7 Specialist external mental health providers (more intensive evidence-based treatment for diagnosed conditions)**

Evidence from the review

The AFP has a range of support networks and programs available to staff that broadly address most of the listed components. Specifically, this includes health promotion, Psychological Support Services, Chaplaincy, ACT Welfare Officers (peer support), employee assistance program (EAP; Davidson Trahaire), external mental health providers, rehabilitation services and the newly established Welfare Officer Network (peer support).

Self-care and looking after colleagues are not presented as an integral part of the AFP model. Although this may be assumed, there is value in explicit recognition of the importance of looking after yourself and colleagues. In relation to this point, there was an interesting reflection from a number of staff that the rhetoric of the AFP being a 'family', with staff 'cared for' throughout their career, may actually serve to undermine individual responsibility for their wellbeing, create unrealistic expectations about the level of service the AFP can provide, and lead to feelings of being let down when expectations do not match reality.

Safe Place, the Confidant Network and the AFP Diversity Staff Networks are excluded from this list because they have a specific function in promoting cultural reform rather than a more general support role.

We were provided with relevant documentation in relation to rehabilitation services, the Welfare Officer Network and the EAP but not in relation to psychology support services, chaplaincy or external mental health providers. With respect to chaplaincy in particular, there is no mention of the chaplaincy service on the organisational chart and no documentation that describes the nature and scope of the chaplaincy service, how it is accessed, its role and responsibilities, or its governance.

Furthermore, there was no overarching document to define the relationship between the various components of the wellbeing services. As a result, there appears to be a range of internal and external services without clear referral pathways, scope of practice, or co-ordination. An additional complication is that services derive funding from different sources rather than centrally. This situation gives rise to the risk of duplication of effort.

Feedback from consultations (including team members and managers) indicated frustration and disappointment in relation to many aspects of these support services as well as confusion about how these services fit together as a coherent whole. Comments from SES staff indicated a lack of awareness of policies to guide decisions about the most appropriate support service for particular issues. Commentary from injured workers indicated an absence of facilitated pathways to getting help, leaving individuals to navigate a disjointed system on their own.

“It is up to the members to push for support – it should be them (AFP) offering support – they are the ones that injured us.” (Injured Member).

Combined, this feedback suggests a lack of coordination across wellbeing services.

A specific problem with the absence of a charter for psychology services was evident in staff feedback on a lack of clarity on whether psychologists were acting on behalf of the organisation or on behalf of staff wellbeing, leading to scepticism about the motivations behind the support. The dual responsibilities of psychologists within the Psychological Support Service in supporting organisational responsibilities (i.e., screening for recruitment/deployment, HR related risk management) as well as clinical responsibilities (i.e., concern for staff welfare, providing confidential treatment, conducting mental health risk assessments and crisis support) needs to be understood and transparent for staff. Specifically, the limits of confidentiality when it comes to mental health issues determined to represent a risk to self or others, needs to be made clear. Although this issue comes into sharp focus for internal psychology support staff, the limits of confidentiality apply equally to external providers.

Rating

Not at all met		Partially met		Entirely met
1	**2**	3	4	5

Criterion 4.2 All staff are aware of the internal and external options for health and welfare support, including the concept of stepped care

Evidence from the review

There seems to be a good general level of awareness of options for support, with 73% of survey respondents indicating that *not* knowing where to get help was not a barrier to care. This was reinforced by focus group findings that most people could name the different services available. However, many staff lacked detailed knowledge about the services, including how they fit together with other available support services.

Consistent with this, our document review indicated that the current model of welfare support does not clearly articulate the concept of stepped care. Staff within the Organisational Health Branch noted that there is not a clear mandate on how or when to use specific services, including Psychological Support Services, such that staff service use decisions are *ad hoc*.

Comments from the staff focus groups indicated that it is not always clear how to get help and that staff often have to advocate for themselves rather than being guided towards appropriate care.

"It is difficult to get support – there are so many avenues, it's complicated." (Staff, ACT).

Poor knowledge of available supports appeared to lead to unrealistic or unmanageable expectations, which gave rise to disappointment or frustration, particularly during crises. An example of this was a member of staff presenting to Psychological Support Services and expecting to be seen for counselling immediately.

Rating

Not at all met		Partially met		Entirely met
1	2	**3**	4	5

Criterion 4.3 Each component of staff support services is accessible and perceived by staff to be helpful

Evidence from the review

We understand that there is currently limited information available on the AFP Hub regarding access to care, options available, where to seek advice, or policies surrounding such issues. The following feedback was received on the existing components of the AFP staff support services.

Chaplains: The visibility of the two Chaplains across the organisation, including regional locations, was high. Among staff who had used the Chaplains in the past year (7% of survey

respondents, n = 147), the survey revealed that they were rated as 'somewhat' to 'very' easy to access (3.8 out of 5) and 'somewhat' to 'very' useful (3.7 out of 5). Feedback from the consultations indicated that Chaplains serve an important role in talking with staff about their wellbeing but it is important to note that comments made in the consultations revealed that not all staff feel comfortable approaching the Chaplain for support due to differences in spiritual beliefs. This raises the potential value of expanding Chaplaincy beyond the Christian faith. The demand for this could be determined in a future staff survey.

Welfare Officers: It is important to emphasise that the new Welfare Officer Network was not operational at the time of the review. Comments regarding welfare officers, therefore, refer primarily to the two ACT Police positions and, to a lesser extent, welfare officers across the organisation before they were phased out several years ago.

The Welfare Officers in ACT Policing were highly regarded throughout the organisation.

"[Welfare officers] are great when they're good, they are a great first point." (Sworn Member, ACT).

The survey revealed that staff who reported using Welfare Officers in the past year (5% of survey respondents, n=113), found them 'somewhat' to 'very' easy to access (average rating of 3.9 out of 5, the highest of all support services) and 'somewhat' to 'very' useful (average rating of 3.6 out of 5).

It is our understanding that following their training, newly appointed Welfare Officers will be based in the regions. Generally, there was enthusiasm for reinstating Welfare Officers across the organisation, although some cynicism was apparent. Specifically, some staff voiced concerns that the roll out of the new Welfare Officer program was a "knee jerk" reaction to bad media, and that it fits within a culture of *"rapid prototyping – get something rolling before it is all figured out." (Sworn Member, NSW).*

"Seems like a knee jerk reaction to Melbourne [member suicide]. It is generally a good idea, hope it is seriously invested in…other resources haven't been successful, how will this be different?" (Sworn Member, NSW).

Concerns were raised in the focus groups about (i) how the new program would be adequately resourced to ensure sustainability and to ensure that officers were not required to do the welfare role on top of a full-time position; (ii) role clarity/scope: what function would they serve and whether they would receive adequate training, (iii) staff selection, and (iv) confidentiality. We note that these issues are addressed in the yet to be released *Better Practice Guide for the Welfare Officer Network*.

Employee Assistance Program (EAP): The current EAP provider is Davidson Trahaire CorpPsych (DTC). DTC is contracted to provide up to six confidential sessions to staff and their immediate family, (i.e., brief psychological interventions). Concerns were consistently expressed in the staff consultations about the EAP provider. Specifically, staff reported that

the EAP was difficult to access (particularly for face-to-face consultations and in remote areas), that there were long waits for appointments, that counsellors were perceived as being poorly qualified or inexperienced, that counsellors were naive with regards to policing related issues/stressors, that different counsellors were provided each time so the individual's concerns needed to be repeated, and that there was poor communication about the quota of services that can be accessed.

Consistent with this feedback, survey respondents who had used the EAP in the past year rated it as the least useful of all the available support services with an average rating of 'slightly' to 'somewhat' useful (2.5 out of 5). The EAP was rated as 'somewhat' to 'very' easy to access (3.4 out of 5).

Positive experiences of the EAP were reported in relation to seeking support for issues not related to work.

AFP Psychological Support Services: Ratings from survey respondents who had accessed psychology services in the past year indicated that the service was 'somewhat' easy to access (3.1 out of 5) but only 'slightly to 'somewhat' useful (2.8 out of 5). On the other hand, most of the feedback gathered in focus groups was positive about the service when received, but still critical about ease of access.

There was consensus in focus group feedback that having access to a psychology service with expertise in organisational and operational challenges of police work was invaluable.

"Need psychs who "get" coppers and behave consistently with common sense" (Sworn member, ACT).

However, staff complained of a lack of visibility (particularly in the regions) and difficulty in accessing the service. Staff in focus groups conducted in the regional offices consistently requested greater local access to Psychological Support Services.

"Support services need to be onsite and properly resourced in the long term" (Sworn Member, NSW).

Feedback from all levels of the organisation indicated that the responsibilities and demands placed upon the service were too high given their limited resources.

"It feels as if they are always stretched." (SES Member).

Attitudes and opinions regarding mental health support services available to AFP personnel are detailed in *Appendix 7: Key themes from the consultations.* Briefly, however, there was concern about perceived cuts to welfare and psychological services over the past decade (noting that this pre-dated the introduction of the Welfare Officer Network), confusion about what is available, and a lack of awareness of how to access support when required. Many people suggested a need to allocate Psychological Support Services to each region and operational area so that AFP personnel have the opportunity to get to know and trust their mental health support staff.

In this context, we understand that psychology support services have experienced significant decreases in FTE and resources over the past decade from 23 EFT to nine. At the time of the review, Psychological Support Services consisted of the Principal Psychologist, two clinical/counselling psychologists, two social workers, two organisational psychologists and two locums (doing project work) all based in Canberra, but who provide services to all states, territories, remote locations and internationally deployed locations. There were no regionally based psychology services. This equates to an approximate ratio of one psychologist/social worker for every 723 AFP staff (based on the head count of 6510), a ratio that is much higher than most other Australian police jurisdictions (Cotton, Hogan, Bull, & Lynch, 2016, p.49). Our impression is that currently Psychological Support Services is not adequately resourced to fulfil its intended function. Further, it would seem that roles and priorities are not clearly articulated, to support the prioritisation of activities undertaken by Psychological Support Services and that physical space and infrastructure also present a barrier to service delivery.

In terms of service usage, most staff who had sought any assistance in the past year (n=953; excludes Safe Place and the Confidant Network), sought it from one or two sources: the average number of places people sought help from was 1.6 out of 5 potential sources [i.e., AFP Psychological Support Services, EAP, external psychologist, ACT welfare officers, chaplains]. Among staff who sought at least one form of assistance (n = 953), just over a third (36%; n = 338) only used external psychologists (i.e., did not use any AFP services).

In summary, the AFP mental health support system is comprised of an appropriate combination of types of care from internal and external providers. However the system lacks an overall coherence, integration and quality assurance, and is under resourced. These shortcomings are reflected in the negative feedback from staff on issues of accessibility and usefulness of services.

Rating

Not at all met		Partially met		Entirely met
1	2	**3**	4	5

Recommendations

We offer the following recommendations for improvement in relation to psychological health and wellbeing services. Please note that recommendations in relation to specific initiatives at Levels I, II and III are included in the relevant sections below.

RECOMMENDATION 9 Establish a stepped care approach to mental health support to ensure that care is co-ordinated and commensurate with need. Funding of mental health support should also be centralised to avoid duplication. A recommended model and rationale for the model is presented below.

RECOMMENDATION 10 With oversight from Organisational Health, establish the role and competencies of Psychological Support Services as coordinating and managing mental health promotion initiatives as well as the range of psychological health and wellbeing support services. This includes: supervision of welfare officers and chaplains; clinical assessment / triage / referral to external providers (EAP and external mental health specialist practitioners); consultation and liaison with rehabilitation providers; and quality assurance and contract management of external providers.

RECOMMENDATION 11 Increase funding to Psychological Support Services to a level commensurate with national benchmarks of approximately 1:250 staff. This would need to be accompanied by a clear mandate for the service to maximise and prioritise what it contributes to the support system. Where possible, allocate Psychological Support Services staff to specific regions and operational areas in order to increase their profile, accessibility and acceptability.

RECOMMENDATION 12 Develop a brochure for staff and families that describes the range of psychological support that are available to them in a stepped care model. In this brochure clearly explain who delivers what interventions or support in each level of care and provide guidance on selecting a service provider based on need and personal preferences (e.g., spiritual guidance, peer who understands the work context, independent person).

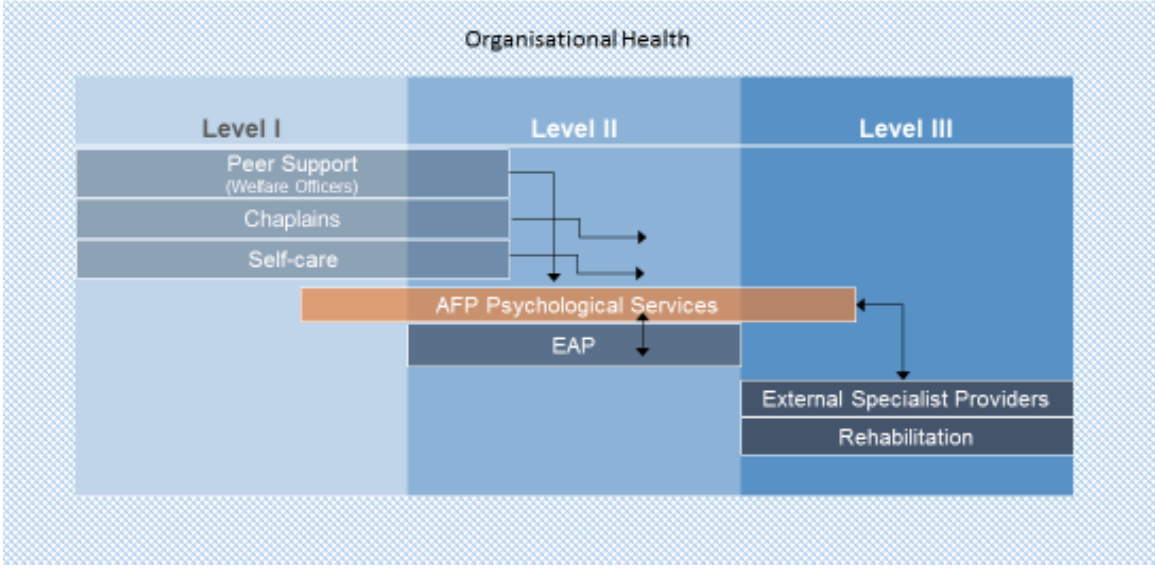


Figure 2. Recommended stepped care model of AFP staff support services

Organisational Health occupies the outer layer of the model, reflecting a broad focus on holistic (mind and body) wellbeing as well as having oversight of the stepped care mode of staff support services. Psychological Support Services are the central coordinating point within the stepped care model with a scope of practice (including coordination, supervision and monitoring) that spans Levels I, II and III. The interventions provided at each level are elaborated below. While individual staff have direct access to all elements of the model, the

Psychological Support Services is well placed take on a triage function guiding individuals to the appropriate level of care as required. Arrows indicate suggested referral pathways.

Rationale for the proposed model

The AFP is a complex organisation with staff working across a diversity of operational areas as well as geographical locations. Providing for the mental health and wellbeing needs of this workforce, from Level I preventative interventions for all staff, to Level II early interventions for staff with emerging or mild mental health concerns through to Level III evidence-based care for those with a mental health disorder is an enormous challenge. The layers of complexity mean that a single or simple solution will not be sufficient. Rather a carefully co-ordinated, stepped care approach that utilises a combination of internal and external services is required. This combination not only allows for staff preference but also avoids an overreliance on one aspect of service provision which can be a vulnerability in times of staff turnover in either internal or external services. All levels of care need to be available across the regions, with checks and balances in place to ensure that the quality of care is never compromised. This requires rigor and consistency in the selection of service providers, and the monitoring of standards of service provision and quality outcomes for AFP staff. These quality assurance mechanisms apply to both internal and external service providers. In addition, investment in critical infrastructure such as an effective digital record and data management system will be necessary for effective implementation.

In our proposed model, Organisational Health is positioned as having oversight of the stepped care model. This oversight could comprise the leadership of medical, rehabilitation and psychological teams to form a health and rehabilitation governance panel. In addition to the stepped care model of mental health supports, we envisage that Organisational Health would have oversight of AFP staff access to a range of holistic wellbeing (mind and body) preventative interventions such as physical fitness, mindfulness and yoga to promote their general wellbeing.

In the proposed model, day-to-day responsibility for the coordination and management of the range of stepped care service providers nationally is delegated to Psychological Support Services, by virtue of their specialist mental health knowledge. The scope of this role includes mental health promotion activities, screening and brief resilience interventions, supervision of non-mental health professional staff such as welfare officers and chaplains; clinical assessment / triage / referral to external providers (EAP and mental health specialist practitioners); and contract management/ quality assurance of external service providers. We believe that there is value in internal mental health staff having capacity to provide brief care to members who prefer to see an internal mental health professional, but this should be limited to 1-6 sessions to ensure that the other critical functions of this service are not compromised.

The range of support services that are currently available to AFP staff, including Welfare Officers, Chaplains, EAP, internal and external mental health specialists and rehabilitation

providers can be readily incorporated into a stepped care approach. However the respective roles and responsibilities of all service providers, and the standards of care required for Level I, II and III interventions, need to be clearly articulated. It is beyond the scope of this review to delineate roles and responsibilities of each element of the service system but given its central coordinating position, the Psychological Support Services is critical to the success of the stepped care model and so warrants particular consideration.

We suggest that the head of the Psychological Support Services be given responsibility for leading the development and oversight of the suite of mental health and wellbeing services. This requires a senior level staff member, preferably a clinical psychologist, with not only the highest quality clinical skills necessary for providing effective support and supervision to other staff, but equally importantly, highly developed skills and expertise in planning and managing mental health service systems, leading multidisciplinary teams, conducting quality assurance activities and collaborating effectively with multiple stakeholders. We would recommend that the incumbent of this role does not have a clinical caseload to ensure that these other functions are not compromised. Other members of the Psychological Support Services team require highly developed clinical skills as well as leadership, collaboration and communication skills. We have suggested that these staff provide limited direct clinical care (1-6 sessions), with their primary role being assessment, triage, coordination, supervision and oversight of the services provided by others (internal and external to the AFP). As is currently the case, the team should be multidisciplinary, including at a minimum clinical psychologists and mental health social workers. To reflect the multidisciplinary nature of this team, consideration may be given to change its name from Psychological Support Services to Mental Health Support Services.

Once the roles and responsibilities of each element of staff support services have been established, quality assurance mechanisms should be put in place to ensure that roles are fulfilled and quality standards are met. Where there are shortcomings in performance, remedial action should be taken. If the quality of service provision does not improve, alternative service providers should be sought.

For internal mental health practitioners, quality assurance mechanisms should include ongoing professional development and supervision, and an annual performance review against KPIs for their role. We envisage that this would be undertaken through line management within Organisational Health Branch. For external practitioners, quality assurance mechanisms should include annual review of services against KPIs, monitoring of treatment plans to ensure they reflect evidence-based treatment approaches, and monitoring of treatment outcomes for service users. We envisage that this would be undertaken by the Psychological Support Services team.

With regard to external service providers, the model specifies that Level II interventions are provided by EAP while Level III interventions are provided by specialist mental health practitioners. This reflects that these levels of care differ with respect to: target group (those with mild or early signs of mental health concerns vs those with mental health disorder); level

of expertise required (general psychological support vs specialist mental health treatment); responsiveness (availability within 1-2 days vs referral for treatment within 1-2 weeks); and length of treatment (1-6 sessions versus longer term treatment). Of course practitioners with appropriate cultural competence and clinical expertise are required at both levels and this should be closely monitored.

An alternative model would be to retain a network of specialist mental health practitioners to deliver both Level II and Level III interventions. The key advantage of this is that it would promote continuity of care for those who move from Level II to Level III care. However we are not aware of such a network currently existing and it would be a major undertaking for the AFP to establish and maintain it. In the absence of such a network, it is also unrealistic to expect individual specialist mental health practitioners to be available at short notice (e.g., 1-2 days) as is required for Level II services.

5. Level I interventions for all staff

Level I interventions include approaches designed to reduce the occurrence of mental health problems either through eliminating potential risks or increasing resilience to manage exposure to operational or organisational stressors. This is also referred to as primary prevention. Level I interventions can be delivered through self-care, by welfare officers, managers, chaplains and psychology services (screening and brief resilience interventions, supervision of non-professional support staff). Level I interventions are offered universally to all staff in the organisation and are not restricted to those with identifiable or emerging mental health issues.

We have organised the findings of our review under key criteria for best practice in the Level I Interventions element of Phoenix Australia's framework.

Criterion 5.1 The organisation conducts regular health promotion activities, with an emphasis on both physical and mental health and wellbeing

Evidence from the review

Objective 2 in the *Mental Health Strategic Action Plan* identifies plans to increase promotion and awareness of mental health. The action plan identifies health promotion strategies that are both organisation-wide (i.e., fact sheets on the Organisational Health Portal) and targeted (i.e., training for high-risk teams). The action plan also identified developing a calendar of endorsed mental health events. Overall, the suggested promotion and prevention activities outlined in the plan are appropriate for Level I interventions.

In terms of current practice, we were aware of a number of health promotion activities initiated by the AFP, including the recent PTSD awareness campaign led by Commander Grant Edwards, and several staff in the focus groups also referred to the AFP supporting initiatives such as 'R U OK Day'. However, there did not appear to be a planned program or calendar of health promotion activities. Consultations with the Organisational Health Branch revealed that the promotion of physical fitness varies by region across the organisation, and that health and fitness programs are not consistently rolled out. Our increasing understanding of the reciprocal relationship between physical and mental health, lends support to the provision of programs with a holistic focus on mind-body interventions such as general fitness, yoga and mindfulness as a preventative measure.

Rating

Not at all met		Partially met		Entirely met
1	2	**3**	4	5

Criterion 5.2 Mental health education and skills training (e.g., mental health literacy including suicide awareness, PFA, resilience) and communication of mental health promotion activities are provided across all stages of the member lifecycle (i.e., recruitment into retirement), tailored to role demands

Evidence from the review

The need for service wide mental health training is highlighted in the mental health strategic framework documents (*AFP Mental Health Framework* and *Mental Health Strategic Action Plan*, *2016 – 2022*). Consultations with staff at all levels of the AFP indicate that this training has not yet been delivered, but we understand from consultations with SES that mental health first aid training is being prepared for roll out to new recruits.

The need for this is supported by feedback from injured workers that they were not provided with tools to foster individual resilience and self-care, and once they became unwell, they often felt powerless over their situation and were not aware of their rights. These concerns were also raised by service groups within the Organisational Health Branch.

Further evidence of the need for this training was found in reports from both senior and all-staff consultations that pejorative language was often used when talking about mental health ("broken biscuits") and perceptions that being known to have a mental disorder (even if it has been successfully treated) is associated with real impacts on career. The staff survey revealed that nearly one-third of staff had definite concerns about seeking assistance due to being worried about putting one's career at risk and fears regarding confidentiality. These were the top two rated concerns with respect to help seeking. Similar patterns were observed across Sworn, Unsworn/Professional and PSO staff.

"People don't want to put their hands up because if you have mental illness or been exposed to events they won't put you in certain roles. This is happening in reality." (Sworn Member, ACT).

Contrary to this broad perception, however, it is worth noting there were some staff who reported a history of mental health problems who did not see this as having adversely impacted on their career.

There was strong support for removing stigma from staff: *"De-stigmatising to the point where people will self-surrender their weapons…where it is no longer 'a thing', just like having a broken leg that will heal." (Sworn Member, NSW).*

Although there was strong support from all levels of the organisation to introduce mental health training initiatives, staff reported concerns that they are too 'time poor' to do additional training and were interested to see how the AFP would adequately resource such initiatives.

Rating

Not at all met		Partially met		Entirely met
1	2	**3**	4	5

Criterion 5.3 Evidence informed information about mental health and wellbeing is easily accessible and highly visible, including self-care advice, what health and welfare resources are available, and how to access them

Evidence from the review

There was no evidence of promotional material regarding mental health being posted in the workplace during our consultation visits. Furthermore, it was unclear whether mental health information is currently available on the Hub. A number of staff indicated that they believed that it is available, but admitted to being unsure how to locate the material as it was not easily accessible or visible. Interviews within the Organisational Health Branch indicated that information about pathways to mental health care, options available, where to seek advice, and policies surrounding such issues are in the process of being made available on the Hub.

Highlighting the importance of staff across all levels of the organisation having access to evidence informed information about mental health and wellbeing, both senior leaders and staff made reference to an informal culture of "looking after your mates", identifying this is one of the most important sources of support for wellbeing. When asked about positive things about working for the AFP, camaraderie was identified in many parts of the organisation as a key strength. However, we did observe variation in different areas of the organisation, which was attributed to capability of team leaders and managers to support this culture.

"I'd have no problems with admitting I'm struggling to my team, not sure about up the chain of command." (Sworn Member, QLD).

"We spend every day with each other, every patrol can be a counselling session." (Sworn Member, QLD).

Rating

Not at all met		Partially met		Entirely met
1	**2**	3	4	5

Criterion 5.4 Implementation of protocols on management of exposure to critical incidents and cumulative stress including:

- **5.4.1 Monitoring the level of individual/group exposure (frequency, intensity)**
- **5.4.2 Provision of acute support (e.g., PFA)**
- **5.4.3 Regular screening of those involved (tailored to role demands and level of exposure)**
- **5.4.4 Facilitated pathways to follow-up support when required**

Evidence from the review

Among survey respondents, the majority of Sworn staff (76%) had been exposed to at least one critical incident in the past 6 months, with an average of 4.6 events experienced among these staff. The three most commonly experienced critical incidents were major or significant

incidents where police response is complex or protracted, viewing objectionable materials, and responding to terrorism related events. The rates of exposure were lower for Unsworn/Professional and PSO staff (average number of critical events was 2.1 and 2.2, respectively).

With the exception of victim-based crime, there do not appear to be any formal policies or procedures to monitor frequency or intensity of exposure to critical incidents and these are managed differently in different areas. For example, it was reported by staff involved in international deployments that they could be sent on multiple high-risk international deployments where they were exposed to critical incidents without reprieve or formal psychological assessment between deployments. On the other hand, some work areas appear to have informal practices initiated by individual managers or teams to monitor staff exposures (again, a culture of "looking after your mates"). For example, within ACT Policing there was evidence that ACT Welfare Officers informally monitored individual member's exposure and liaised with managers to support member wellbeing.

With respect to organisational response to critical incidents, staff made reference to a policy on critical incident response that has not been updated in a long time. Staff raised concerns that the AFP's response to critical incidents is '*ad hoc'*, suggesting that the policy is not consistently implemented.

ACT Policing Welfare Officers attend critical incidents and provide acute support consistent with PFA, although it was not clear whether these officers had undertaken formal training in PFA. This level of support was highly regarded by staff who were currently working within ACT Policing, as well as by staff who had left this area. Indeed, on several occasions, staff spoke highly of the camaraderie and psychosocial support offered in ACT Policing, which was attributed in part to the maintenance of Welfare Officers within this division.

The newly released policy regarding the Welfare Officers' Network (August, 2017) indicates a role in critical incident response but does not specify what level of training these officers will receive in relation to managing exposure to critical incidents.

With respect to screening, some high-risk areas, such as child exploitation (within victim-based crime), have policies that involve mandatory psychological assessments every 6 months. Combined with informal check-ins from team managers on a regular basis and mental health awareness on the part of staff, this is a reasonable screening frequency. While there was no defined tenure on child exploitation work, information from consultations indicated that staff were able to request transfers out of this area, which were typically granted.

For international deployments, pre- and post-deployment screening appears to be considered by staff to be ineffective and under resourced. It was commonly reported by staff that they believed psychological screens prior to deployment were never properly checked by anyone within the AFP ("tick and flick"), and it was common for post-deployment screening to

occur many months after returning from post, leading to increased cynicism about the value the organisation places on staff wellbeing. Staff also had concerns about the experience and qualifications of contractor staff used by the AFP to conduct post-deployment assessments.

We did not see any evidence of a consistent approach or pathway to follow up support following critical incidents.

Rating

Not at all met		Partially met		Entirely met
1	**2**	3	4	5

Criterion 5.5 Personnel are encouraged and supported in activities that enhance physical fitness, tailored to role demands

Evidence from the review

A recent policy documentation (*Road2Ready – Physical Health Concept Paper 2017 – 2020*) lays out a model for improving physical health of AFP staff across different roles and across the member lifecycle. This policy appropriately acknowledges links between physical fitness and mental health outcomes (including burnout), and proposes that the model will be implemented over the next 3 years. The approach is consistent with best practice and provides an excellent framework for developing appropriate and effective policies and procedures to enhance mental health and wellbeing of staff.

Currently, however, there are inconsistent approaches to promotion of physical fitness across the organisation. For example, some teams were given time during work hours to use AFP gym facilities, whereas others were given access out of hours. These discrepancies did not appear to be tied to job role/demands. Further, there was significant variability in the quality and accessibility of gym facilities and exercise programs across the organisation. The Health and Fitness team reported that programs are not consistently rolled out across the regions as responsibility for the rehabilitation program rests at a local level.

It would appear from staff consultations that inconsistencies in resources available for health promotion have fostered perceptions of region-based favouritism. For example, there was a strong perception that Headquarters in Canberra has state of the art facilities relative to other regions and the bonuses for passing fitness tests exclusively available to SES level staff are perceived as unfair by others, particularly operational staff.

The value placed on physical fitness was reflected in the survey in that ‘finding the time to stay in good physical condition’ was rated as one of the most important operational stressors across all roles in the organisation. PSO staff who responded to the survey ranked occupation-related health issues (e.g., back pain) as the top operational stressor (average rating of 4.0 out of 7, equating to ‘moderate stress’).

Rating

Not at all met		Partially met		Entirely met
1	2	**3**	4	5

Recommendations

We offer the following recommendations for improvement in relation to Level I interventions for all staff. Please note that while monitoring staff wellbeing is an important component of Level I, recommendations in this area are included in Section 8 Monitoring Staff Wellbeing.

RECOMMENDATION 13 Further develop the Critical Incident policy to ensure consistency with best practice approaches (e.g., PFA), to assist welfare officers and managers to identify signs of concern, and provide information on referral pathways if required.

RECOMMENDATION 14 Promote the self-care component of the stepped care model through a service wide roll out of mental health first aid and skills training on looking after yourself and looking out for your mates. A team-based approach would be ideal to promote a sense of shared responsibility. Provide backfill or overtime to ensure that staff are given the necessary time to take part in the roll out.

RECOMMENDATION 15 Implement flexible solutions for physical fitness programs and resources that are commensurate with the role requirements of staff, and available regardless of location. For example, in regions without access to AFP facilities, the AFP should support staff access to locally available health and fitness activities.

6. Level II interventions for staff with mild or emerging mental health concerns

Level II interventions include approaches designed to detect and address early signs of mental health concern prior to the development of mental disorders. This is also referred to as secondary prevention. Psychological Support Services staff may provide Level II interventions as well as having a central role in training, supervising and supporting welfare officers and chaplains in the provision of Level II interventions and ensuring the quality of services provided through the EAP.

We have organised the findings of our review under key criteria for best practice in the Level II Interventions element of Phoenix Australia's framework.

Criterion 6.1 Deliver evidence-based interventions that address problems associated with sub-clinical or mild mental health problems or other psychosocial stressors (i.e., self-care, coping resources, emotion regulation and stress management)

Evidence from the review

Discussions with Psychology Support Services staff reflected a sound knowledge of evidence-based interventions for sub-clinical problems and/or psychosocial stressors. However, the capacity to deliver these interventions is hindered by inadequate resources for the team.

The EAP brochure lists the scope of problems that can be addressed by the EAP. These include workplace issues such as conflict, change, adjustment, critical incident stress as well as personal issues such as relationships, grief and loss, gambling, and a range of mental health issues including depression, anxiety, alcohol and substance abuse issues. Feedback from staff consultations suggests that the EAP is better equipped to help with non-work-related issues than policing issues as they do not have a good understanding of the police culture. An additional concern noted by a number of people was that they saw a different counsellor for each of their sessions with the EAP, which undermines treatment effectiveness, even if an evidence-based approach is being used. (We should note that the EAP provider, DTC, denied that this was an issue, insisting that most people saw the same counsellor every session. They believed the problem occurred only when a person engaged with DTC, then "dropped out" of treatment for a while, then recontacted – at that point, they would be classed as a new referral and offered a new counsellor).

Rating

Not at all met		Partially met		Entirely met
1	2	**3**	4	5

Criterion 6.2 Appropriate processes are in place to ensure that evidence-based methods are used by the organisation's psychological services and external providers endorsed by the organisation (e.g., EAP) including:

6.2.1 Quality assurance review mechanisms for both internal and external providers

6.2.2 Appropriate initial training and ongoing professional development for all internal welfare and psychological support staff to ensure care is appropriate for presenting problems

6.2.3 Regular clinical supervision by an appropriately qualified supervisor of all internal welfare and psychological support staff

6.2.4 Clear contractual obligations (e.g., regarding qualifications/experience of providers, timeliness, consistency of providers) are in place for EAP providers

Evidence from the review

Staff in Psychological Support Services are required to maintain appropriate professional registration (AHPRA/AASW), which includes a requirement for supervision with an appropriately qualified supervisor. It appears that a number of staff make private arrangements for this supervision. Review mechanisms for quality assurance for internal welfare services were not apparent during the review.

The newly released policy regarding the *Welfare Officers' Network (August, 2017)* states that Welfare Officers must complete training in appropriate methods of assisting and supporting staff affected by personal or work-related demands, pressures and stress. The scope of practice appears appropriate for Level II support; however, the content of this training was not ready for review by Phoenix Australia. We note that clinical support for Welfare Officers will be provided by "an AFP employee from Organisational Health Branch", although the qualifications required of the person providing clinical support is not specified. A psychologist or social worker with specialist expertise in mental health would be appropriately qualified.

The contractual agreement with DTC clearly defines standards of practice consistent with Level II service provision and the required qualifications, experience and supervision of personnel providing services to the AFP (an appropriate postgraduate qualification and 5+ years of postgraduate experience). We note however, that the qualifications and experience of individuals listed as providing service to the AFP were not provided and although supervision is made available on a monthly basis, it is unclear whether this occurs. Further, the requirement for consistency of providers in any given case is not specified in the contract.

We understand that due to concerns about inadequate oversight, the responsibility for managing the DTC contract has been moved from Psychological Support Services to a non-mental health specialist. It is the view of the review team that management of this contract, including the capacity to ensure the quality of the services being provided, requires mental health expertise.

Rating

Not at all met		Partially met		Entirely met
1	2	**3**	4	5

Criterion 6.3 Protocols are in place to ensure regular monitoring and review of referrals to external providers (EAP)

Evidence from the review

As would be expected in the interests of client confidentiality, AFP staff and their families can access the EAP directly, without going through the AFP. As such the AFP does not receive information about individual service users. DTC, however, is required to provide regular (de-identified) statistics regarding service usage patterns. Staff within the Organisational Health Branch indicated a perception that DTC is underutilised due to its poor reputation within the organisation. In response to this, we understand that the issue has been formally raised with DTC and the contract adjusted to raise the standard of the service. The staff focus groups indicated variability in staff understanding of the service and its limitations. Representatives of DTC were concerned not only about underutilisation of counselling services, but also that many of the other services offered by DTC (e.g., manager support, training in various mental health areas) were effectively not used at all by the AFP.

Rating

Not at all met		Partially met		Entirely met
1	2	**3**	4	5

Recommendations

We offer the following recommendations for improvement in relation to Level II interventions for staff with sub-clinical or mild mental health problems or other psychosocial stressors.

RECOMMENDATION 16 Return responsibility for managing the EAP contract to Psychological Support Services staff who are well placed to determine whether the qualifications, experience and supervision of the EAP is appropriate and whether their approach to service provision reflects best practice. This should occur only after the recommendations in relation to Psychological Support Services (resourcing and quality assurance) have been implemented.

RECOMMENDATION 17 Undertake a review of the EAP contract, including the suitability of the current EAP, to ensure that individuals providing services to AFP staff are appropriately qualified (preferably as clinical psychologists), understand the work of the AFP (cultural competence) and provide consistency in service provision (i.e., individuals see the same counsellor for each of their up to six sessions).

RECOMMENDATION 18 To avoid unrealistic expectations, provide information to staff on the service, and limitations to service, provided by the EAP. This may be in the form of a regular staff information session provided by the EAP where concerns can be addressed.

7. Level III interventions for staff with mental health disorder

Level III interventions include approaches designed to reduce the longer-term impact of mental health disorders on occupational functioning and quality of life, through evidence-based treatment and rehabilitation. This is also referred to as tertiary prevention. These interventions could be provided by both internal Psychological Support Services staff and external mental health specialists, depending on organisational priorities for the internal psychologists. Level III interventions also include rehabilitation services.

We have organised the findings of our review under key criteria for best practice in the Level III Interventions element of Phoenix Australia's framework.

Criterion 7.1 Internal psychological support staff are aware of, and able to refer to, appropriately qualified mental health specialists for provision of evidence-based treatments to personnel with diagnosable conditions

Evidence from the review

The AFP does not currently have a system of preferred providers with known skills for treating mental health concerns arising from police work. We understand that there used to be a referral database but this has not been maintained or formalised. Feedback in the staff focus groups was supportive of staff having a choice to access internal psychology or external psychologists who were familiar with working with police.

The processes to ensure access to Level III services for injured workers deployed internationally, or those in regional and remote areas are not clear.

Due to limited capacity/high demands associated with other routine tasks across the portfolio, Psychological Support Services are currently unable to provide adequate Level III care to staff. We see this primarily as a resourcing issue, not one of capability. There is certainly value for staff in having access to internal psychologists who understand the unique requirements and stressors of policing. However, this needs to be balanced against the value to the organisation of having the internal psychologists providing specialist advice to the organisation so they are informed consumers of Level III services and coordinators of care rather than delivering clinical services.

Rating

Not at all met		Partially met		Entirely met
1	**2**	3	4	5

Criterion 7.2 AFP ensures external providers have necessary information about AFP operational requirements and risk assessment procedures

Evidence from the review

No evidence of this was provided and in the absence of a preferred provider network, it seems unlikely that information about AFP operational requirements and risk assessment

procedures is routinely available to external providers. Psychological Support Services reported concerns that their capacity to professionally oversee the treatment provided externally had diminished due to their current workload, and voiced concerns that their lack of involvement in this process may further marginalise injured staff. The review team believe that this involvement is also important to ensure that external providers have access to trusted advice and guidance on the implications of an individual's mental state and risk profile in the context of AFP operational requirements.

Rating

Not at all met		Partially met		Entirely met
1	**2**	3	4	5

Criterion 7.3 The accessibility and acceptability of externally provided mental health services are regularly monitored and reviewed

Evidence from the review

There was no evidence from our review that the work undertaken by external mental health specialists is regularly monitored and reviewed.

Rating

Not at all met		Partially met		Entirely met
1	2	3	4	5

Criterion 7.4 Psychological support services work closely with internal rehabilitation personnel to support staff with mental health problems to stay at work where possible (through modified hours / duties, extra supports) and to retain engagement with workforce

Evidence from the review

Existing policy documentation relating to the Work Health and Safety Rehabilitation Division (which includes the Injury Management team) does not describe coordination between Rehabilitation Services, Psychological Support Services and Medical Services. Interviews with both injured staff and Organisational Health Branches indicated that communication and coordination between these service divisions is poor. Injured staff raised issues with the lack of coordination and case management leading to them having to tell their story to multiple services before being able to access appropriate care. According to staff within the Injury Management team, there are no mental health-specific rehabilitation policies and case managers in Injury Management are not necessarily clinically trained. Many do not have sufficient mental health knowledge or skills to inform, assess or guide appropriate return to work for staff with mental health problems, in the absence of collaboration with Psychological Support Services. Unfortunately, there was a perception that organisational support for positive transitions to work following a psychological injury was lacking. Staff in the Injury Management team and regionally based rehabilitation officers highlighted large caseloads and lack of resources as barriers to providing appropriate care.

Feedback from injured staff about rehabilitation services were mixed.

"Part of the return to work was to be given a meaningful role ASAP. Unfortunately, I had 5 months of not doing a great deal. Again, there is no one to blame it's just that there wasn't any process for a monitored reintegration back into the work force." (Injured Member).

Rehabilitation Officers highlighted challenges for people returning to work.

"[It is] very difficult to place people who cannot be operational."

"Members are supported by teams when they return. Problem is when they aren't able to return to full role quickly, the sympathy reduces the longer they are on the RTW process". (Rehabilitation Officer).

Perspectives from Rehabilitation Officers indicated that a manager's awareness of mental health is an important predictor of how well someone will cope with return to work.

Examples from both the Injury Management team and interviews with injured staff who had been through the return to work process indicated mixed levels of capability among managers to support the rehabilitation process. Several adverse scenarios were described: managers bullying injured personnel upon return to work, injured workers not consulted about work placements and often placed in unnecessarily menial tasks, and managers using someone's mental health issues to manage them out of the organisation.

"[The AFP] needs a more nuanced response to RTW. Can't just be you are here or not." (Member, ACT).

Rating

Not at all met		Partially met		Entirely met
1	**2**	3	4	5

Criterion 7.5 A close working relationship exists between the organisation and its workplace insurer in order to minimise adversarial interactions between worker and insurer, to minimise the stress associated with the claims process, and to facilitate a healthy return to work where possible, especially for psychological injury

Evidence from the review

Several family members who participated in the teleconferences related the wide-ranging, adverse impacts of Comcare claims on the member and the family. They highlighted how costly (i.e., personal financial burden), stressful and adversarial the process was, and that there was no support from the AFP, who they felt did not have the member's interests in mind. With regards to return to work procedures "[*We] felt like a number in the system….[I] have concerns that there isn't a support system in place…[it is] not an environment that will offer a genuine rehabilitation pathway."(Family member supporting an injured worker)*.

The majority of injured staff that were interviewed described the return to work process and their Comcare claims as difficult, slow and adversarial. Most held negative beliefs toward the

AFP's role in this process, and believed that the organisation hindered rather than helped their recovery.

"You are as good as not covered." (Member, NSW).

"My pathway into being a 'mental health user' was after a workplace injury….Comcare and AFP management of my injury/position, has contributed significantly to the pressures of long term acute pain/reduced sleep etc. … I would expect that those injured in the work 'space' unnecessarily end up with mental health issues."(Injured Member).

Rating

Not at all met		Partially met		Entirely met
1	**2**	3	4	5

Recommendations

We offer the following recommendations for improvement in relation to Level III interventions for staff who have developed a mental health condition.

RECOMMENDATION 19 When referrals are made to external mental health specialists, the AFP should provide specific information regarding AFP's operational requirements and risk assessment procedures (e.g., management of, and access to, firearms).

RECOMMENDATION 20 Improve the process and outcomes of return to work following mental injury by training Injury Management case managers in mental health first aid and establishing a collaborative approach between Injury Management and Psychological Support Services towards agreed goals. This should follow the increase in resourcing to Psychological Support Services.

RECOMMENDATION 21 Establish a patient centred approach to claims management in collaboration with Comcare to minimise the distress associated with injury claims and the associated potential for exacerbation of injury.

RECOMMENDATION 22 Explore the potential for a system of non-liability health care for mental health conditions amongst sworn members and PSOs, enabling immediate access to care.

RECOMMENDATION 23 Provide staff with transition counselling if they are unable to return to previous role after mental injury.

RECOMMENDATION 24 Engage the services of external mental health specialists with experience and expertise in working with emergency services personnel and/or Defence. For the sake of efficiency and consistency in service, consider engaging the services of an existing organisation with national reach.

8. Monitoring wellbeing

We have organised the findings of our review under key criteria for best practice in the Monitoring Wellbeing element of Phoenix Australia's framework.

Criterion 8.1 Regular (e.g., annual) assessments are made of organisational climate / morale and mental health / wellbeing with all staff encouraged to participate

Evidence from the review

We note that the AFP undertakes annual staff engagement surveys (AFP Staff Survey). The scope of the survey includes organisational challenges, overall rating on working at the AFP, bullying and harassment, AFP core values, staff retention, staff engagement, leadership, the working environment (working conditions, performance development, workplace health and safety), communication, leave, diversity, training, code of conduct, and effective administrative processes. It is not clear how the results of this survey are used by the AFP.

We note also that the scope of this survey does not extend to mental health and wellbeing. The data collected in the survey conducted as part of this Mental Health Review will serve as a useful benchmark to monitor staff wellbeing in an ongoing way and measure the impact of future mental health and wellbeing initiatives.

Rating

Not at all met		Partially met		Entirely met
1	2	**3**	4	5

Criterion 8.2 All staff are encouraged to participate in routine monitoring of their own psychological wellbeing in order to facilitate early identification, encourage self-care, and promote help seeking when appropriate

Evidence from the review

There was no evidence that staff are encouraged or provided with the tools to routinely monitor their own wellbeing.

"Early detection is rare…there is a lack of self-awareness about mental health." (Rehabilitation Officer).

Rating

Not at all met		Partially met		Entirely met
1	2	3	4	5

Criterion 8.3 Managers have a role in promoting the wellbeing of their staff through monitoring, supporting, and facilitating access to support services if required

Evidence from the review

Staff feedback indicated significant variability in the extent to which managers routinely monitor the stress and wellbeing of their staff.

"The support you get will depend on the team leader." (Sworn member, NSW).

Senior leaders indicated that there is often a lack of follow up and contact with staff when they are sick and managers reported that they are unsure of what their responsibilities are when it comes to monitoring the wellbeing of staff, especially those with mental disorders.

"[The AFP doesn't] hold the information (in terms of in online systems) so people are falling through cracks. Information is not maintained – this is a risk…got no data about people's disabilities therefore managers are very stuck in how to respond to someone with an issue." (Member, ACT).

Managers at all levels do not currently have any key performance indicators related to team wellbeing.

"There are no KPIs for morale." (PSO Member).

Rating

Not at all met		Partially met		Entirely met
1	**2**	3	4	5

Criterion 8.4 Staff in high-risk roles are required to undergo regular mental health screening tailored to role demands (e.g., every 6 to 12 months depending on exposure levels)

Evidence from the review

Some high-risk areas, particularly those involved in viewing objectionable materials (Digital Forensics, Child Protection), have sound policies in place to screen and monitor wellbeing. The *AFP Practical Guide on Wellbeing Support for Members dealing with Explicit Material* and *AFP National Guideline on Managing Child Exploitation Material* are two documents that provide guidance on minimising the risks associated with viewing of objectionable material. They recommend regular psychological screening; and describe the role of `hot debriefs' and how explicit material should be managed and stored. In general, these practices were well-regarded by staff involved, although some comments in the staff focus groups and individual interviews/submissions expressed concerns that people were not rotated quickly enough out of these high-risk areas and that psychological assessments were limited to "tick and flick" questionnaires. Managers in these areas noted that maintaining a high standard of practice with respect to these policies in regional areas was a significant challenge.

Commentary from the staff focus groups revealed perceptions that screening assessments pre- and post- deployment on international missions were inadequate, especially when this process was outsourced to non-AFP contractors.

"Post deployment check-ins are 'tick and flick', it is always a new person every time, you never feel that you could open up, I'm not sure anything good or supportive would happen….It is hopeless…an 'arse covering' system." (Member, NSW).

"Face-to-face check-ins would be more productive." (Member, NSW).

Requests were made in the staff focus groups for better supports to be made available for high-risk roles, including joint task forces.

Rating

Not at all met		Partially met		Entirely met
1	2	**3**	4	5

Recommendations

We offer the following recommendations for improvement in relation to monitoring wellbeing.

RECOMMENDATION 25 Incorporate mental health questions into the annual AFP survey and use the results to a) monitor overall staff wellbeing and b) evaluate the impact of mental health and wellbeing policies, procedures and support services.

RECOMMENDATION 26 Develop an information management system linked to HR systems to track staff exposures to traumatic and other stressors as well as staff absenteeism, to enable managers to monitor exposures and staff wellbeing.

RECOMMENDATION 27 Implement and encourage staff to use an anonymous online survey that allows them to monitor their own wellbeing on a regular basis, provides feedback on their current (and, ideally, past) wellbeing levels, and makes recommendations for self-help, peer/chaplaincy support, EAP, or specialist mental health treatment based on their responses.

RECOMMENDATION 28 Broaden routine and regular mental health screening and monitoring processes to all high-risk areas of the organisation. Identification of high-risk areas should be informed by an up-to-date critical incident register, which includes exposure to psychological risk. Targeted screening with a mental health professional should be conducted every 6-12 months for staff in high-risk roles, depending on number of critical incidents experienced and/or levels of cumulative exposure to potentially traumatic events. Monitoring of staff working in these areas should continue annually for two years post rotation.

RECOMMENDATION 29 A two-phased approach to screening should be undertaken after deployment. An initial screen within the first two weeks would determine any immediate mental health needs and provided targeted psychoeducation on readjustment risks. A subsequent screen, up to six months later would assess readjustment and identify any delayed mental health concerns.

9. Separation from the organisation

We have organised the findings of our review under key criteria for best practice in the Separation from the Organisation element of Phoenix Australia's framework.

Criterion 9.1 Strategies are in place to prepare personnel for separation from the organisation (e.g., information packs, individual counselling/coaching, group education sessions) with a view to promoting a positive transition

Evidence from the review

As noted earlier, transition out of a high-risk organisation can be very challenging and associated with increased risk of mental health problems. Uniformed members in particular may have to adjust to significant changes in their identity and status, occupation, finances, routines, responsibilities, supports and culture. Transition support in other high-risk organisations often focus on providing information and practical assistance on employment seeking, financial management, available support networks, and how to seek health/mental health care in the future as required.

There was no evidence in policy documents, or from staff consultations that similar strategies to prepare staff for separation from the organisation in order to support positive transitions are in place.

Rating

Not at all met		Partially met		Entirely met
1	2	3	4	5

Criterion 9.2 A network of ex-employees is in place (e.g., social media groups, local activities, awareness of available resources) to provide support/advice to both current and ex-members

Evidence from the review

There is currently no ex-AFP network to support and provide advice to current and ex-members, although several staff at all levels of the organisation recommended or supported the idea.

"We should establish a retired members' network and think about how to draw on the expertise of people who have stepped down due to injury" (SES Member).

Rating

Not at all met		Partially met		Entirely met
1	2	3	4	5

Recommendations

We offer the following recommendations for improvement in relation to separation from the AFP for uniformed members.

RECOMMENDATION 30 Prepare staff for separation from the AFP though the provision of a) transition seminars and information packs on job seeking, financial matters, and health and wellbeing; and b) individual consultations with a HR staff member to develop a transition plan and refer for counselling/coaching as required.

RECOMMENDATION 31 Support the establishment of an ex-employee network as a source of mutual social and practical support and advice. The AFP's role in this network would not be to run it but to provide practical support, guidance and ongoing connection, for example drawing upon the experience of ex-employees for the benefit of new recruits and serving members.

10. Engagement with families

Friends and families play an essential role in looking after AFP staff: staff survey results indicated that family/friends were the top-rated source of support that AFP staff would seek out if they were experiencing concerns about work stress or wellbeing [76% of staff rated it likely or very likely that they would seek support from family/friends]. A similar pattern was observed among staff who reported high levels of psychological distress at the time of the survey [support from family/friends was the top-rated source of support, with 63% rating it as likely or very likely they would seek support from family/friends].

We have organised the findings of our review under key criteria for best practice in the Engagement with Families element of Phoenix Australia's framework.

Criterion 10.1 Beginning at recruit training there are regular sessions for families to provide information (e.g., what it is like to have a family member in the service, simple self-care strategies, professional health and welfare resources) and to encourage mutual support networks

Evidence from the review

In the introduction, the *Mental Health Framework* document identifies that the *"The AFP values the commitment members make to law enforcement and feels a responsibility to support the wellbeing of staff and their families"*. The document also acknowledges the impacts police work can have on families and the role families play in supporting AFP staff. However, families are not mentioned in the *Mental Health Strategic Action Plan* and there was no evidence of formal documentation regarding the dissemination of mental health information to families.

Participants in the family member teleconference groups noted that formal information sessions or networks to help families support AFP staff would be highly useful but do not currently exist. Family members expressed concern that the longer-term impacts of traumatic events (months or years following exposure) were not monitored, leaving it up to families to manage in isolation and without access to appropriate supports or information about what services are provided by the AFP.

Family members had variable knowledge of the support services available to them (e.g., EAP) and to their serving family member. There appeared to be no formal channels for them to gain access to information about professional health and welfare resources.

We note that AFP family members are eligible to access EAP counselling services through DTC and receive the same service as serving members.

Rating

Not at all met		Partially met		Entirely met
1	**2**	3	4	5

Criterion 10.2 Strategies are in place to encourage engagement of families (and local communities where appropriate) throughout the member lifecycle, such as regular bulletins on initiatives within the organisation, information on support services, and "family days" where practical

Evidence from the review

Currently there does not appear to be any formal engagement on the part of the AFP with families.

Rating

Not at all met		Partially met		Entirely met
1	2	3	4	5

Criterion 10.3 There are formal mechanisms in place for families' perspectives and concerns to be heard and considered by the organisation

Evidence from the review

We understand that there are currently no formal mechanisms in place for two-way communication with families of AFP staff. The range of issues raised in the family teleconferences reinforced the value of such a mechanism.

Several family members raised concerns about not being informed by the AFP about high-risk missions involving their family member. Family members described scenarios where they were unable to make contact with their serving family member (due to remote location/mission constraints), and they did not receive any updates from the AFP during the period the member was uncontactable. In some cases, widespread media coverage (for example, of local violence) in the absence of any specific information from the AFP, served to substantially exacerbate fears for their loved one's safety. There does not appear to be any policies, systems or mechanisms in place within the AFP to provide this critical service to families.

Support systems and procedures (i.e., relocation support services, social support networks to help integration) to reduce the impact of the 'mobility clause' on families are lacking. The staff focus groups and submissions from family members revealed perceptions that funding to support rotations (i.e., relocation costs) are inconsistently applied and that these perceived inequities create underlying tensions within some teams.

Several members reported adverse impacts of the 'mobility clause' on family relations. The pressure to move was particularly difficult for members who may be separated from children for extended periods of time. Staff expressed disappointment that the AFP often appeared unable to take into consideration family circumstances when making decisions about transfers.

Rating

Not at all met		Partially met		Entirely met
1	2	3	4	5

Recommendations

We offer the following recommendations for improvement in relation to engagement with families.

RECOMMENDATION 32 Include a session for families at recruit training (e.g., what it is like to have a family member in the service, simple self-care strategies, professional health and welfare resources) and encourage mutual support networks. This could be supported by a family portal on the Hub.

RECOMMENDATION 33 Establish mechanisms for ongoing two-way communication with families including regular (e.g., monthly) information bulletins, provision of a point of contact within Psychological Support Services for family members and annual family days across AFP work locations. These mechanisms should be used to reinforce and build on topics covered during the family sessions in recruit training. This is particularly important while the member is on overseas deployment.

11. Continuous improvement

We have organised the findings of our review under key criteria for best practice in the Continuous improvement element of Phoenix Australia's framework.

Criterion 11.1 The organisation's senior leadership group receives regular reports on member wellbeing and each level of psychological welfare and support (internal and external), identifies potential problems as early as possible, and acts accordingly

Evidence from the review

The AFP has established a Mental Health Strategy Board whose role it is "to shape the AFPs mental health strategy". Given this mandate the review team was surprised by the absence of any mental health professionals on the Board.

Organisational Health staff consultations highlighted that, in the absence of e-health records, it is not possible to conduct the regular audits and reviews necessary to examine mental health statistics at an organisational level. This organisational level perspective on mental health is critical to informing the mental health strategy as it allows examination of organisational as well as individual resilience factors in influencing mental health outcomes. Staff expressed concern that, in the absence of this organisational perspective, the cause of mental health problems is attributed to the individual rather than being recognised as an interaction between the individual and organisational factors, and that this contributes to stigma.

There do not appear to be mechanisms currently in place for regular review of each element of the support services. We understand from Psychological Support Services that their capacity to oversee the quality assurance of the range of support services has been compromised by resource cuts and the quality assurance mechanism for the Psychological Support Services itself, was unclear.

Rating

		Partially met		Entirely met
Not at all met				
1	**2**	3	4	5

Criterion 11.2 Regular evaluations and audits (3 yearly) of approaches used by psychological and welfare support services to ensure continual improvement and alignment with best practice

Evidence from the review

There was no evidence of formal charters or audits of the work being undertaken by the range of psychological and welfare support services that could be used to benchmark services against best practice in an ongoing way.

We note again the decline over time in the capacity of Psychological Support Services to have oversight of the work being conducted in other internal or external staff support services or to provide a quality assurance function, with a reduction from 23 EFT to the current nine.

Rating

Not at all met		Partially met		Entirely met
1	**2**	3	4	5

Criterion 11.3 The organisation has strong relationships with comparable organisations in order to share knowledge and improve practice in mental health and wellbeing initiatives

Evidence from the review

The *Draft AFP Mental Health Framework* and *Mental Health Strategy* emphasises the need to build psychological potential within the AFP and Organisational Health Branch, through a collaborative approach, expert advice and comprehensive and integrated mental health services. The *Mental Health Strategy Action Plan* lists an initiative to *"Establish strategic partnerships with leading mental health and other associated organisations"* with an approximate allocated annual budget of $35,000.

Towards this goal, we note that in May 2017, the AFP co-sponsored (with Victoria Police and the Northern Territory Police) and hosted a roundtable on trauma related stress in primary responders. The roundtable was facilitated by not-for-profit think tank Australia 21 and health promotion charity, Fearless.

Furthermore, Workforce Development leaders are fostering relationships with the Australian Institute of Policing Management regarding manager training, which includes training in wellbeing and the AFP is adapting the Victoria Police and The Police Association Equipt mobile application. We note also that the AFP is part of the Australia New Zealand Policing Advisory Agency.

Despite these connections, feedback from staff consultations indicated that staff believe that the AFP could do a better job with learning from other organisations about their approach to mental health.

Rating

Not at all met		Partially met		Entirely met
1	2	3	**4**	5

Recommendations

We offer the following recommendations for improvement in relation to continuous improvement.

RECOMMENDATION 34 Although we understand that the Mental Health Strategy Board is administrative rather than clinical, its role in shaping the mental health strategy indicates that the Board should include at least one mental health professional.

RECOMMENDATION 35 Use the electronic health record to generate high level summary statistics of mental health issues across the organisation, for regular review by the Commissioner via Organisational Health Branch or other appropriate leadership group.

RECOMMENDATION 36 Have each component of the wellbeing support services prepare an annual report to Organisational Health Branch on their activities and outcomes.

RECOMMENDATION 37 Review and benchmark the approaches used by psychological and welfare support against best practice on a three-five yearly basis to ensure they keep abreast with best practice.

Implementation

On the following pages the recommendations are rated for priority using the following colour coding.

Priority for implementation
Priority 1 Implement within 1 year
Priority 2 Implement within 1-2 years
Priority 3 Implement within 3-5 years

This is intended as a blue print that can be used to guide continual improvement over the next 3-5 years. In communications with staff, it may be helpful to communicate the full suite of recommendations so that individual initiatives are understood in the context of the overall plan rather than being seen as reactive or quick fixes.

Recommendation
1. Organisational Factors
Areas of concern noted but recommendations are beyond the scope of this review.
2. Mental health policy framework
Priority 1 commence implementation within 1 year
RECOMMENDATION 1 Build on the current mental health strategic plan to develop a comprehensive framework for the evaluation of mental health policy implementation that: a) identifies the gaps in existing policy documentation; b) delineates a plan for the development of the necessary policy documents; c) addresses how the policy is to be disseminated across the organisation; d) outlines what training and support is to be provided to staff who have responsibility for implementing components of the policy; e) details the intended impacts of the policy; and f) explains how these will be measured.
RECOMMENDATION 2 Develop a policy and procedure document that outlines: a) the role of each component of staff support services; b) the relationships between each component, reflecting a stepped care approach; c) referral and access pathways;d) confidentiality and privacy considerations; e) governance arrangements; and f) quality assurance mechanisms.
Priority 2 commence implementation within 1 - 2 years
RECOMMENDATION 3 Introduce an electronic health record that can be shared across each component of staff support services.
3. Managers and leaders
Priority 1 commence implementation within 1 year
RECOMMENDATION 4 To promote help-seeking, communicate to staff that senior leadership views mental health injuries as able to be rehabilitated until proven otherwise, and provide clear guidelines around when and why decisions relating to changes to operational status will be taken.
RECOMMENDATION 5 Develop policy and procedure documents that provide guidance to managers on how to manage mental health concerns in their staff, including how to identify mental health issues, make necessary referrals, and make decisions about operational issues such as security clearance and the removal of accoutrements. These documents should specifically address how policy and procedures apply in remote and regional areas.

Priority 2 commence implementation within 1 - 2 years
RECOMMENDATION 6 Include leadership and people management skills as key performance indicators in the position descriptions for all managers in the AFP.
Priority 3 commence implementation within 3 - 5 years
RECOMMENDATION 7 Establish compulsory leadership training as a prerequisite for promotion to management positions across the AFP. This should be face-to-face training, wherever possible.
RECOMMENDATION 8 Ensure that all managers within the AFP undergo mental health and psychological first aid (PFA) training on a regular (2-3 yearly) basis to maintain currency. After the initial training, refresher training could be conducted online.
4. Psychological health and wellbeing support services
Priority 1 commence implementation within 1 year
RECOMMENDATION 9 Establish a stepped care approach to mental health support to ensure that care is coordinated and commensurate with need. Funding of mental health support should also be centralised to avoid duplication.
RECOMMENDATION 10 With oversight from Organisational Health, establish the role and competencies of Psychological Support Services as coordinating and managing mental health promotion initiatives as well as the range of psychological health and wellbeing support services. This includes: supervision of welfare officers and chaplains; clinical assessment / triage / referral to external providers (EAP and external mental health specialist practitioners); consultation and liaison with rehabilitation providers; and quality assurance and contract management of external providers.
RECOMMENDATION 11 Increase funding to Psychological Support Services to a level commensurate with national benchmarks of approximately 1:250 staff. This would need to be accompanied by a clear mandate for the service to maximise and prioritise what it contributes to the support system. Where possible, allocate Psychological Support Services staff to specific regions and operational areas in order to increase their profile, accessibility and acceptability.
Priority 2 commence implementation within 1 - 2 years
RECOMMENDATION 12 Develop a brochure for staff and families that describes the range of psychological support that is available to them in a stepped care model. In this brochure clearly explain who delivers what interventions or support in each level of care and provide guidance on selecting a service provider based on need and personal preferences (e.g., spiritual guidance, peer who understands the work context, independent person).
5. Level I interventions for all staff
Priority 1 commence implementation within 1 year
RECOMMENDATION 13 Further develop the Critical Incident policy to ensure consistency with best practice approaches (e.g., PFA), to assist welfare officers and managers to identify signs of concern, and to provide information on referral pathways if required.
Priority 2 commence implementation within 1 - 2 years
RECOMMENDATION 14 Promote the self-care component of the stepped care model through a service-wide roll out of mental health first aid and skills training on looking after yourself and looking out for your mates. A team-based approach would be ideal to promote a sense of shared responsibility. Provide backfill or overtime to ensure that staff are given the necessary time to take part in the roll out.
Priority 3 commence implementation within 3 - 5 years

RECOMMENDATION 15 Implement flexible solutions for physical fitness programs and resources that are commensurate with the role requirements of staff, and available regardless of location. For example, in regions without access to AFP facilities, the AFP should support staff access to locally available health and fitness activities.
6. Level II interventions for staff with mild or emerging signs of mental health concerns
Priority 2 commence implementation within 1 - 2 years
RECOMMENDATION 16 Return responsibility for managing the EAP contract to Psychological Support Services staff who are well placed to determine whether the qualifications, experience and supervision of the EAP is appropriate and whether their approach to service provision reflects best practice. This should occur only after the recommendations in relation to Psychological Support Services (resourcing and quality assurance) have been implemented.
RECOMMENDATION 17 Undertake a review of the EAP contract, including the suitability of the current EAP, to ensure that individuals providing services to AFP staff are appropriately qualified (preferably as clinical psychologists), understand the work of the AFP (cultural competence) and provide consistency in service provision (i.e., individuals see the same counsellor for each of their up-to-six sessions).
RECOMMENDATION 18 To avoid unrealistic expectations, provide information to staff on the service, and limitations to service, provided by the EAP. This may be in the form of a regular staff information session provided by the EAP where concerns can be addressed.
7. Level III interventions for staff with a mental health disorder
Priority 1 commence implementation within 1 year
RECOMMENDATION 19 When referrals are made to external mental health specialists, the AFP should provide specific information regarding AFP's operational requirements and risk assessment procedures (e.g., management of, and access to, firearms).
Priority 2 commence implementation within 1 - 2 years
RECOMMENDATION 20 Improve the process and outcomes of return to work following mental health injury by training Injury Management case managers in mental health first aid, and establishing a collaborative approach between Injury Management and Psychology Services towards agreed goals. This should follow the increase in resourcing to Psychological Support Services.
RECOMMENDATION 21 Establish a patient-centred approach to claims management in collaboration with Comcare to minimise the distress associated with injury claims and the associated potential for exacerbation of injury.
RECOMMENDATION 22 Explore the potential for a system of non-liability health care for mental health conditions amongst sworn members and PSOs, enabling immediate access to care.
RECOMMENDATION 23 Provide staff with transition counselling if they are unable to return to previous role after mental injury.
Priority 3 commence implementation within 3 - 5 years
RECOMMENDATION 24 Engage the services of external mental health specialists with experience and expertise in working with emergency services personnel and/or Defence. For the sake of efficiency and consistency in service, consider engaging the services of an existing organisation with national reach.
8. Monitoring wellbeing
Priority 2 commence implementation within 1 - 2 years

RECOMMENDATION 25 Incorporate mental health questions into the annual AFP survey and use the results to: a) monitor overall staff wellbeing, and b) evaluate the impact of mental health and wellbeing policies, procedures, and support services.
RECOMMENDATION 26 Develop an information management system linked to HR systems to track staff exposures to trauma and other stressors as well staff absenteeism, to enable managers to monitor exposures and staff wellbeing.
RECOMMENDATION 27 Implement and encourage staff to use an anonymous online survey that allows them to monitor their own wellbeing on a regular basis, provides feedback on their current (and, ideally, past) wellbeing levels, and makes recommendations for self-help, peer/chaplaincy support, EAP, or specialist mental health treatment based on their responses.
RECOMMENDATION 28 Broaden routine and regular mental health screening and monitoring processes to all high-risk areas of the organisation. Identification of high-risk areas should be informed by an up-to-date critical incident register, which includes exposure to psychological risk. Targeted screening with a mental health professional should be conducted every 6-12 months for staff in high-risk roles, depending on number of critical incidents experienced and/or levels of cumulative exposure to potentially traumatic events. Monitoring of staff working in these areas should continue annually for two years post-rotation.
RECOMMENDATION 29 A two-phased approach to screening should be undertaken after deployment. An initial screen within the first two weeks would determine any immediate mental health needs and provided targeted psychoeducation on readjustment risks. A subsequent screen, up to six months later, would assess readjustment and identify any delayed mental health concerns.
9. Separation from the organisation
Priority 3 commence implementation within 3 - 5 years
RECOMMENDATION 30 Prepare staff for separation from the AFP though the provision of: a) transition seminars and information packs on job seeking, financial matters, and health and wellbeing; and b) individual consultations with an HR staff member to develop a transition plan and refer to counselling/coaching as required.
RECOMMENDATION 31 Support the establishment of an ex-employee network as a source of mutual social and practical support and advice. The AFP's role in this network would not be to run it but to provide practical support, guidance and ongoing connection, for example, drawing upon the experience of ex-employees for the benefit of new recruits and serving members.
10. Engagement with families
Priority 2 commence implementation within 1 - 2 years
RECOMMENDATION 32 Include a session for families at recruit training to provide information (e.g., what it is like to have a family member in the service, simple self-care strategies, professional health and welfare resources) and to encourage mutual support networks. This could be supported by a family portal on the Hub.
Priority 3 commence implementation within 3 - 5 years
RECOMMENDATION 33 Establish mechanisms for ongoing two-way communication with families including regular (e.g., monthly) information bulletins, provision of a point of contact within psychology services for family staff, and annual family days across AFP work locations. These mechanisms should be used to reinforce and build upon the family session in recruit training. This is particularly important while the member is on overseas deployment.
11. Continuous improvement
Priority 1 commence implementation within 1 year

RECOMMENDATION 34 Although we understand that the Mental Health Strategy Board is administrative rather than clinical, its role in shaping the mental health strategy indicates that the Board should include at least one mental health professional.
Priority 2 commence implementation within 1 - 2 years
RECOMMENDATION 35 Use the electronic health record to generate high level summary statistics of mental health issues across the organisation for regular review by the Commissioner via Organisational Health Branch, or other appropriate leadership group.
RECOMMENDATION 36 Have each component of the wellbeing support services prepare an annual report to Organisational Health Branch on their activities and outcomes.
RECOMMENDATION 37 Review and benchmark the approaches used by psychological and welfare support against best practice on a three to five-yearly basis to ensure they keep abreast with best practice.

Concluding comments

We do not underestimate the challenges involved for organisations opening themselves up for external review of their approach to managing mental health issues. We commend the AFP for its open and transparent approach, facilitating our engagement with staff across all levels of the organisation. We also thank every member of staff who gave their time to contribute to the review in good faith. We sincerely hope that our review and recommendations will provide a roadmap for ongoing improvement within the AFP.

Important to say that we similarly do not underestimate the time, fortitude and commitment that will be required to implement the recommendations from the review. We appreciate the challenge for the AFP of striving to meet the expectations of staff, while ensuring that changes and new initiatives are introduced, in a considered and sustainable way. That all of this occurs within an environment of fiscal constraint, public interest and media attention, increases the challenge many fold.

A comprehensive evaluation framework is beyond the scope of this report but we offer a template, see Appendix 9, as a structure for the evaluation of implementation of the recommendations. The template provides a rating against four components: documentation, implementation, monitoring and evaluation, and outcomes, reflecting the stages of implementation.

Appendices

Appendix 1: Scope of work

Phoenix Australia has been requested by the Australian Federal Police to undertake a detailed mental health services review. This document provides a brief overview of the procedures involved in the review.

Step 1. Literature review (including grey literature)

In Step 1 we will undertake a review of the peer review and grey literature (publicly available reports) on mental health in policing and like organisations to inform the questions to be addressed within the review. The literature review will examine:

(a) the prevalence of posttraumatic stress disorder and other mental health disorders in comparable organisations (we would suggest policing including child exploitation and counterterrorism as well as defence);

(b) the workplace factors and stressors in these organisations that impact on mental health;

(c) best practice approaches to managing these workplace factors and stressors; and

(d) best practice approaches to ensuring early and evidence based treatment for staff who develop mental health problems.

Step 2. Review of AFP documentation

In advance of consultation meetings, Phoenix Australia will review the *AFP Mental Health Framework 2016-2022,* the *AFP Mental Health Strategic Action Plan 2016-2022*, and the *Cultural Change: Gender Diversity and Inclusion in the Australian Federal Police* report. We will also request and review all available documentation on AFP operations, general policies relevant to staff wellbeing that address workplace stressors such as critical incidents, bullying and fatigue, and policies that relate to staff support, as well as any specific policies for staff working in high trauma areas such as child pornography, counter terrorism and overseas deployment.

Step 3. Face-to-face consultations with senior leaders, union and staff support personnel

We will undertake interviews with senior leaders across the organisation (for example, at the national manager level) and union representatives to understand their perspectives on general and specific workplace factors that impact on the wellbeing of their staff, and their views on AFP's current approaches to identifying and managing psychological risks including the accessibility, effectiveness and barriers to uptake of staff support services. We will also undertake interviews with staff support personnel (e.g., psychologists) to gather information on the policies and procedures for staff support, common presenting problems and intervention approaches (e.g., treatment/referral/quality assurance), as well as their perception of the accessibility, effectiveness and barriers to uptake of staff support services.

The cost of the face-to-face consultations will be $53,000 excluding GST.

Step 4: Staff focus groups

We will undertake a series of staff focus groups (approximately 40) to cover staff across the main locations within Australia (Canberra, Sydney, Melbourne, Brisbane and Perth) and across the key roles of investigations & prevention, community policing, protective services, international police assistance, criminal asset litigation, liaison & partnership, forensics, specialist capabilities (including intel, surveillance, tactical operations, covert) and corporate services. The focus groups will gather staff perspectives on workplace factors that impact their mental health and how those factors could be mitigated, knowledge of current supports and systems for managing wellbeing, perspectives on the accessibility, effectiveness and barriers to support service uptake. The process for identifying staff to be invited to attend focus groups will be agreed in discussion between Phoenix Australia and AFP. Invitees should be a representative sample of AFP staff as far as possible. AFP will take responsibility for recruiting staff to take part in focus groups. In support of this, Phoenix Australia will provide an information sheet for staff about the purpose of the focus groups.

Step 5: Development of an online survey for all AFP staff

The detailed information gathered in staff focus groups will be used to inform the development of an online survey. This survey will ensure that all AFP staff have the opportunity to contribute to the mental health review. The proposed scope of the survey (subject to agreement) includes sources of workplace stress (organisational and operational factors in addition to particular traumatic stressors), knowledge of current supports and systems for managing psychological wellbeing, perspectives on accessibility, effectiveness of supports and barriers to service uptake and current mental health and wellbeing. If the survey includes questions on current mental health and wellbeing (as recommended), it will require ethics approval.

Step 6: Undertake online survey of all AFP staff

We propose the following approach to the online survey.

- Phoenix Australia will develop a promotional information sheet and poster about the survey to be distributed to staff and displayed in workplaces. We have not built in costs for these materials to be professionally designed and printed but will do so if this is required.
- AFP to provide an email distribution list for staff
- Phoenix Australia to distribute initial warm up email to all staff, which will briefly introduce the survey
- Phoenix Australia to distribute invitation to participate in survey
- Phoenix Australia to distribute reminder emails on a weekly basis to staff who have not completed the survey

We suggest that the survey be open for six weeks. At the close of the survey Phoenix Australia will collate, analyse and write up the results.

Step 7: Final report

Phoenix Australia will prepare a draft report with recommendations based on the information gathered through each component of the review. The draft report will be submitted to AFP for feedback on any additional information that should be considered and suggested amendments to the recommendations to improve clarity and ease of implementation. The final report will then be submitted. We would also be happy to provide a brief plain language summary of the mental health review process, findings and recommendations for feedback to AFP staff.

Step 8: Presentations (costed for up to three presentations)

We have included in our budget the cost of developing a presentation and having Professor Forbes and Dr Phelps delivering up to three presentations to relevant stakeholders within AFP.

Timeline

The project could be completed within 10 months of commencement, see Gantt chart below.

AFP Mental Health Review REVISED project timeline

Step in the project	M 1	M 2	M3	M 4	M 5	M 6	M 7	M 8	M 9	M 10
S1: Literature Review										
S2: Review of documentation										
S3: Face-to-face consults										
S4: Staff focus groups										
S5: Development of online survey										
S6: Undertake online survey										
S7: Final report										
S8: Presentations										

Appendix 2: About Phoenix Australia

Phoenix Australia – Centre for Posttraumatic Mental Health (formerly the Australian Centre for Posttraumatic Mental Health) is an independent, not-for-profit organisation, affiliated with the Department of Psychiatry, University of Melbourne. Phoenix Australia is an international leader in building the capability of individuals, organisations and the community to understand, prevent and recover from the adverse mental health effects of trauma. Our work spans across research and evaluation, policy and service development, and education and training, with each stream informing and being informed by, the others.

Phoenix has an established track record working with high-risk industries such as Defence, rail, police and other emergency service organisations. We support organisations to employ best practice approaches to:

- Recognising psychological hazards in the workplace
- Minimising the risk of staff exposure
- Managing potential impacts on staff

Our advice is based on the international peer review literature where it exists and in the absence of a research evidence base, expert consensus opinion. Phoenix Australia work of particular relevance to this project includes:

- Development of the NH&MRC approved Australian Guidelines for the Treatment of Acute Stress Disorder and Posttraumatic Stress Disorder (2007, 2013)
- International Consensus Guidelines for Peer Support in High-Risk Organisations
- Implementation and evaluation of Psychological first aid (PFA) in high-risk organisations
- St John Ambulance WA Review of Workplace Mental Health Risks
- Ambulance Victoria Review of Psychology and Staff Support Services
- The Australian Defence Force Mental Health Screening Continuum Framework
- Trauma management framework for the Australian rail industry
- Trauma management framework for the Australian media industry
- Three level framework to promote recovery for communities affected by disaster
- Leadership of an international roundtable in post-disaster mental health with the engagement of HRH Prince of Wales
- PTSD Consensus Guidelines for Emergency Service Workers (member of the expert advisory panel)

The Phoenix Australia Director, Professor David Forbes, also sits on numerous Commonwealth policy and research advisory committees relating to the mental health and wellbeing of current and ex-serving members of Defence and is the Vice Chair of the international PTSD Guidelines organised through the International Society for Traumatic Stress Studies.

Appendix 3: AFP business area descriptions

AFP Business Area	Description
ACT Policing	ACT Policing's mission is to keep the peace and preserve public safety within the ACT. We strive to deliver a professional and effective service to the people of Canberra in all that we do.
Crime Operations	The Crime Operations Portfolio is responsible for providing a law enforcement response to a range of crime types including but not limited to illicit drugs, people smuggling, human trafficking, child sex offences. AFP Crime Operation teams work through collaborative relationships with domestic and overseas partners.
Counter Terrorism	Counter Terrorism contributes to safeguarding Australia's national security, through a whole of government approach, facilitated by national and international cooperation, coordination and collaborative working arrangements.
International Operations	One of the AFP's key areas of emphasis is to contribute to Australia's international law enforcement interests through cooperation with key international partners to Combat transnational organised crime and corruption, respond to emergencies, participate in mandated peace operations, provide law and order capacity building missions to enhance rule of law internationally and contribute to regional stability, contribute to Australia's border management and security; and deliver policing services to identified External Territories and coordinate the Pacific Transnational Crime Network.
Org. Crime and Cyber	Organised Crime (OC) investigates dynamic and complex organised criminal activities including but not limited to money laundering, the importation and distribution of illicit drugs, the importation and distribution of precursor chemicals used in the manufacture of illicit drugs.
People, Safety and Security	PSS's aim is to provide responsive and forward-looking human resource policies, strategies and systems in support of AFP operational and other business needs, both now and into the future. PSS services focus on the recruitment and development of a healthy, skilled, diverse and professional workforce through integrated employee services and initiatives.
Protection Operations	The Protection portfolio delivers a superior level of service through a commitment to client service, training, staff recruitment, advanced technology and quality assurance. We guarantee Commonwealth standards of probity and accountability, combined with the best of public and private sector expertise.
Specialist Operations	Specialist Operations portfolio is made up of Intelligence and Forensics functions. Intelligence provides a single picture of the criminal threats and harms relevant to AFP activity enabling investigators to be intelligence informed in their decision making. The Forensic function provides forensic science and technical intelligence services in support of AFP operations at the Australian Capital Territory (ACT) community policing level, nationally and internationally. The function is a fully integrated forensic capability, which plays a role in investigations from the crime scene to the courtroom.

AFP Business Area	Description
Support Capability	Support Capability (SC) harnesses a broad range of specialist expertise and world leading technical capabilities to enrich the AFP's investigative outcomes. Capabilities maintained and delivered by SC directly support the management of transnational and serious and organised crime and response to off-shore crisis. SC directly supports the AFP's effort in contributing to policing for a safer Australia.
Technology and Innovation	T&I deliver an extensive and complex range of commercial, government, specialist law enforcement and bespoke applications. These systems operate across geographically dispersed, fixed, deployable and mobile networks and on most types of modern hardware and communications bearers.
Workforce and Development	The Workforce and Development portfolio comprises of Learning and Development (L&D) and AFP State Office teams. The primary role of L&D is to design and deliver training programs and to assist in coordinating and managing learning needs at both an individual and organisational level.
Chief of Staff	The Chief of Staff (CoS) portfolio supports the Commissioner in ensuring effective AFP engagement with external stakeholders and the AFP's contribution to the development and implementation of government policy.
Reform, Culture and Standards	The Reform, Culture and Standards portfolio was created to oversee the 24 recommendations stemming from the “Cultural Change Report: Gender Diversity and Inclusion in the AFP” report. All 24 recommendations are an ongoing focus of attention for the organisation.
Chief Financial Officer	Finance and Commercial contributes to the financial accountability of the AFP through providing guidance and advice on financial, resource and property management.
Legal	AFP Legal is the AFP's in-house legal practice, comprising legal professionals and support staff, who provide legal advice and assistance to all functional areas of the AFP.

Appendix 4: Literature review

The AFP play a critical role in the policing of Australia at both local and international levels, providing a diverse range of policing services including community policing, international operations, protection services, counter terrorism, organised and cyber crime, and victim-based crime. A description of all the business areas within the AFP is provided in *Appendix 8: Staff survey: Method and results.* As a result of repeated exposure to dangerous and often traumatic incidents in their regular work tasks, police personnel and other emergency workers in general, are considered to be at higher risk of developing mental health conditions than the general community. It is important to acknowledge that many operational stressors cannot be eliminated from police work. In this section we briefly review evidence from the published literature describing both sources of stress and the mental health impacts associated with police work. This literature was used to guide the selection of questions included in the staff consultations and survey.

Sources of stress in policing

Studies of occupational stress indicate that policing involves exposure to unique types of acute and chronic stressful events, which are associated with impaired psychosocial wellbeing and physical health (Berg, Hem, Lau, Håseth, & Ekeberg, 2005; Gershon, Barocas, Canton, Xianbin, & Vlahov, 2008; Lucas, Weidner, & Janisse, 2012; Magnavita & Garbarino, 2013; McCreary & Thompson, 2006). Sources of stress in policing have been classified into two broad domains. Operational stressors relate to the nature of police work and organisational stressors relate to the nature of police organisations.

Operational factors

Operational stressors in policing are varied, ranging from routine stressors such as shift work, court appearances and paperwork, to increased risk of exposure to danger and critical incidents. While three quarters of Australian adults are exposed to an incident that may potentially be traumatic at some point during the course of their life (Mills et al., 2011), this number is much higher for occupational groups such as police officers and firefighters (Kaufmann, Rutkow, Spira, & Mojtabai, 2013). It has been estimated that police officers experience, on average, over three critical incidents for every six months of service (Patterson, 2001).

Operational aspects of police work expose officers to emotionally demanding situations, including critical incidents, and are associated with self-reported stress (Kop, Euwema, & Schaufel, 1999). Emotionally demanding situations include informing relatives of a sudden death, fatal accidents, criminal or sexual offences with children, and requirements to use violence as well as the dangers associated with the work, such as violence and aggression against officers and terrorist acts. A further source of stress for police involves coping with negative perceptions and disappointing outcomes of police actions, for example, negative attitudes of civilians toward police officers, lack of respect from the public and inadequate punishment of crime (Kop et al., 1999).

Organisational factors

Many useful reviews of the research evidence supporting the importance of organisational health in influencing both financial and human outcomes are available and a detailed overview of that literature is beyond the scope of this report. A good starting point, however, is "Working Together: A mental health guide for APS managers" developed and published by the Australian Public Service Commission and Comcare in 2013. The following summary of evidence from recent research findings is adapted from that document.

- Organisations with strong organisational health (i.e., investment in quality people management) typically exhibit better service delivery performance (Keller & Price, 2011).
- Organisational health is associated with stronger financial performance, typically 2.2 times above average (Keller & Price, 2011).
- Approximately 30% of the variation in service delivery outcomes at a team level is attributable to organisational climate, specifically, the quality of supportive leadership and people management practices (Cotton & Hart, 2012).
- 70% of failed organisational change programs are attributable to poor organisational health (Keller & Price, 2011).
- Just under 7% of staff in any organisation will develop clinically significant depressive symptoms in any one year (OECD, 2012).
- On average, every full-time staff with untreated depression costs an organisation $9,665 per year (OECD, 2012).
- Implementing effective early intervention programs results in a five-fold return on investment, due to increased staff productivity (Hilton, 2004).
- Supportive leadership and sound people management can reduce frequency and costs of workers' compensation premium rates. This impact extends beyond psychological injury claims. National research indicates that workplace psychosocial factors can contribute up to 59% of the risk for the onset of musculoskeletal injuries in the workplace (Hauke, Flintrop, Brun, & Rugulies, 2011).
- Ensuring people with mental health conditions are able to keep their job will boost productivity and support social inclusion (OECD, 2012).
- Removing obstacles to keeping staff at work, and minimising time off work, is associated with better long term mental health and wellbeing outcomes (Rueda et al., 2012).
- Early intervention—specifically, early identification and facilitating access to quality mental health care—is associated with a 492% return on investment (calculated by comparing early intervention and treatment costs with subsequent reduction in absenteeism and improvement in work performance) (Whiteford, Sheridan, Cleary, & Hilton, 2005).

In addition to these specific studies, recent systematic reviews of the research literature provide powerful evidence supporting the benefits of organisational interventions in improving mental health outcomes (e.g., Joyce et al., 2016). Taken together, this body of research evidence highlights the importance of addressing any organisational factors that might be adversely affecting the psychological health and wellbeing of AFP personnel.

What organisational factors are important?

A large body of research in the field of occupational stress has explored those organisational factors that appear to influence psychological health and wellbeing. The research findings consistently point to several core aspects of the work experience that have the potential to adversely affect the mental health of staff, including the following (MacKay et al., 2004).

- **Demands:** issues such as workload, work patterns, and the work environment
- **Control:** how much say the person has in the way they do their work
- **Support:** the encouragement, sponsorship and resources provided by the organisation, line management and colleagues
- **Relationships:** promoting positive work practices to avoid conflict and dealing with unacceptable behaviour
- **Role:** whether people understand their role within the organisation and whether the organisation ensures they do not have conflicting roles
- **Change:** how organisational change (large or small) is managed and communicated in the organisation

The organisational culture (the commitment to reducing occupational stress, improving wellbeing, and ensuring that procedures are fair and open) underpins these components, with aspects of culture driving, and incorporated into, each of the above domains.

In addition to these factors that are common across different types of organisation, there is a literature on organisational factors specific to police organisations. Organisational factors are highlighted as important sources of stress among police officers and it has been suggested that organisational factors are more prevalent and experienced as more stressful than many operational stressors faced by officers (Biggam, Power, Macdonald, Carcary, & Moodie, 1997; Brown & Campbell, 1990; Brown & Campbell, 1994; Toch, 2002). Self-reported sources of organisational stress among police officers include staff shortages, inadequate resources, time pressure, lack of communication, and work overload (Biggam et al., 1997; Brown & Campbell, 1990; Brown & Campbell, 1994).

Studies of police officers in the United States report that a lack of administrative coordination or guidance, discrimination, harassment, lack of influence in the agency, work-family conflict, and lack of organisational fairness are associated with higher levels of work stress, whereas camaraderie with fellow officers was associated with lower levels of stress (Gershon et al., 2008; He, Zhao, & Archbold, 2002; He, Zhao, & Ren, 2005; McCarty & Skogan, 2012; McCarty, Zhao, & Garland, 2007; Morash, Kwak, & Haarr, 2006). A study of Canadian police officers identified competing demands, non-supportive organisational culture, understaffing and pressures to perform work outside one's mandate as antecedents to work-role overload, a form of occupational stress (Duxbury, Higgins, & Halinski, 2014). Among Australian police officers, job overload (i.e., being asked to do too much in a specific time frame or without the proper equipment) was associated with higher levels of work stress (Noblet, Rodwell, &

Allisey, 2009). In a study of Dutch police officers, Kop et al. (1999) also found organisational stressors, such as poor management, reorganisation, and bureaucratic interferences, to be associated with job stress. Among police officers in India, organisational politics, work overload, and work-family conflict was associated with higher levels of work stress (Tyagi & Dhar, 2014).

Making the distinction between organisational and operational stressors is helpful for identifying sources of stress and for informing ways of mitigating their potential impacts. However, it is also important to recognise that these two sources impact and influence one another. A strong and supportive organisational culture may assist in protecting officers from the stress of operational exposures. There are consistent reports that police officers who experience higher levels of organisational support report lower work stress (Noblet et al., 2009; Tyagi & Dhar, 2014). Social support from supervisors has also been highlighted as protective against mental health problems in policing: a recent longitudinal study found that officers who received higher levels of support from a supervisor whilst engaging in work with high-risk of exposure to critical incidents had lower secondary traumatic stress responses one year later (Craun, Bourke, Bierie, & Williams, 2014). These findings highlight that it is important for policing organisations to identify ways that they can maximally support staff when they engage in unavoidable, high-risk operational tasks.

Prevalence of mental health disorders in policing

This section presents international data on the prevalence rates of mental health disorders in police personnel and emergency workers, compared to the general population; firstly, for PTSD, then for mental health outcomes more broadly (e.g., depression, anxiety). Figures were sourced from available literature and articles identified within our review, and the most recent estimates, where available, are reported. The *beyondblue* National Mental Health and Wellbeing of First Responders Prevalence Study currently underway will be invaluable in providing the most relevant and current Australian rates (D. Lawrence (UWA), personal communication, 2017).

PTSD

Police Personnel

Police officers are exposed to traumatic events as part of their occupation and are therefore considered to be at higher risk of developing PTSD than the general population. Further, exposure to traumatic experiences as part of police work has been shown to be more strongly predictive of PTSD symptoms than non-work related traumatic experiences (Stephens & Miller, 1998). Estimates of prevalence of PTSD among police officers vary between 4.7% and 26 %. For example, Carlier, Lamberts and Gersons (1997) found that 7% of the Dutch police officers in their sample met criteria for PTSD and 34%had partial or sub-threshold PTSD. Estimates of around 7% have been replicated in two additional studies, one of which involved US police officers, and the other involving New Zealand police officers (Hartley, Sarkisian, Violanti, Andrew, & Burchfiel, 2013; Stephens & Miller, 1998). Robinson,

Sigman and Wilson (1997) found that 13% of their sample of US police officers had diagnosable PTSD. A pilot study with Queensland police officers found an 8% PTSD prevalence rate for work-related events (Rallings, 2000), whereas one US study found PTSD prevalence to be as high as 26% among US police officers (C. A. Martin, McKean, & Veltkamp, 1986). A recent meta-analysis (combining data from many studies) reported that the PTSD prevalence among police personnel from around the world who were involved in post-disaster rescue work was 4.7 % (Berger et al., 2012). This estimate comes from data on nearly 5000 police officers from many different countries and uses both self-report and clinical interview data. However, it should be noted that this review only included studies of police who had been involved in rescue work after a major disaster, and did not include studies of police who have not been in disaster rescue work. As such, this finding is not likely to be truly representative of PTSD prevalence for general duties police officers.

A study of early retirements from the New Zealand Police found that 16.8% of early retirees were diagnosed as having posttraumatic reactions, and the majority (69.2%) of early retirees cited psychological reasons for leaving (Miller, 1996 cited in Stephens & Miller, 1998). A study by Karlsson and Christianson (2003) revealed that the event most police officers considered most distressing and stressful occurred early in their careers and that 32% of traumatic events experienced by the officers occurred during their first five years on the job.

Inconsistencies in the rates reported in the above studies may be due to differences in the nature of the policing experiences and to differences in the measurement strategies used. Studies that directly compare subtypes of police personnel (analysts, investigators/ detectives, community, special forces) are scarce, such that it is difficult to establish whether particular types of police work are associated with elevated risk for PTSD. Such difference may, however, go some way towards explaining variability in prevalence estimates.

Although the female gender is consistently found to have to be associated with the risk of developing PTSD in the general population, this finding has not been consistently found in police officer samples. The meta-analysis examining rescue workers following natural disaster found no association between PTSD prevalence and gender across all rescue worker studies (Berger et al., 2012) although, as 75% of these study samples were comprised of at least 85% male participants, gender differences may be hard to detect.

Comparisons to other populations

Existing evidence suggests that prevalence rates of PTSD may be only slightly elevated amongst policing personnel compared to the general population. Likely prevalence rates of PTSD between 5% and 8% in police personnel compares to rates of 1.3%-7.2% for lifetime PTSD prevalence in the general population across various countries (Kessler, Chiu, Demler, Merikangas, & Walters, 2005; McEvoy, Grove, & Slade, 2011). The 12-month prevalence rate for PTSD is estimated to be 3.5% in the general US population (Kessler et al., 2005) and 4.4% in the general Australian population (Chapman et al., 2012). In a study of New Zealand police officers, it was shown that the prevalence of PTSD symptoms in working police

officers was similar to that in other civilian populations who have experienced a traumatic event (Stephens & Miller, 1998).

Estimated prevalence rates of PTSD among Australian Defence Force personnel is 8.3% (Hodson, McFarlane, van Hooff, & Davies, 2011).

Prevalence of other mental health disorders and general psychological co-morbidity

Multiple studies from around the world reveal that police officers experience a range of other mental health problems in addition to, and often comorbid with, PTSD. To our knowledge, there are no epidemiological or meta-analytic studies examining the prevalence of these mental health disorders among police officers, and prevalence estimates across studies tend to vary. Data collection methods also vary between the studies (i.e. prevalence rates estimated through comprehensive diagnostic interviews versus self-reported survey data), which means that results across studies cannot be directly compared. Until results are available from the National Mental Health and Wellbeing of First Responders Prevalence Study, the most reliable comparable rates are those from the ADF Mental Health and Wellbeing Prevalence Study. Prevalence rates reported in the ADF study are provided below as a reference point where applicable.

Depression and anxiety

Rates of major depressive disorder and levels of depression symptoms are reported as higher among police officers than the general population (Chen et al., 2006), however the reported prevalence of depression has a wide range from 10.6% among Sri Lankan police officers (Wickramasinghe, Wijesinghe, Dharmaratne, & Agampodi, 2016) to 37.2% among Australian police officers (Lawson, Rodwell, & Noblet, 2012).

Comparisons of police officers to other occupational groups on self-reported clinical and subclinical mental health problems suggest that police officers do not experience serious mental health problems (primarily depression and anxiety symptoms) more than other occupations (Kaufmann et al., 2013; van der Velden et al., 2013), although in a sample of protective service workers (firefighters, police officers and guards), exposure to a greater variety of critical incidents was associated with greater odds of developing a mood disorder (Kaufmann et al., 2013). Moderate levels of anxiety were reported among 617 Italian police officers (Acquadro Maran, Varetto, Zedda, & Ieraci, 2015), with anxiety levels varying as a function of gender and role type (executives, unit managers, officers, non-commissioned officers and patrol officers). Specifically, patrol officers reported the highest anxiety of all policing roles, and anxiety was more elevated for males than females. Among staff with management responsibilities, females (both commissioned and non-commissioned) tended to have higher anxiety levels than males (Acquadro Maran et al., 2015). The ADF mental health and wellbeing study found 12-month prevalence rates of depression and anxiety disorders in current serving staff of the ADF of 6.4% and 14.8%, respectively (Hodson et al., 2011).

Sleep

Police work has been associated with increased risk for sleep and substance use problems, which elevate risk for other adverse health outcomes. One study reported that 40% of police officers suffered from at least one type of sleep disorder and these were significantly associated with increased risk of self-reported adverse health, performance, and safety outcomes (Rajaratnam et al., 2011). Prevalence of sleep disorders were not reported in the ADF mental health prevalence study.

Substance use

Studies have found that police officers tend to have higher rates of problematic drinking than the general population (Richmond, Wodak, Kehoe, & Heather, 1998), with an estimated 37% of Australian police officers meeting criteria for alcohol use disorders (Davey, Obst, & Sheehan, 2001). In a nationally representative sample of US protective service workers (police, firefighters, guards), lifetime prevalence of alcohol-use disorders were similar to that of adults in other occupations (Kaufmann et al., 2013). The ADF mental health prevalence study found a 12-month prevalence rate of 5.2% in current serving staff, which was lower than community rates of 8.3% (Hodson et al., 2011).

Burnout

Police work is considered to be highly stressful, which can culminate in burnout. Burnout is a syndrome encompassing emotional exhaustion, feeling alienated and cynical, particularly about work activities, and reduced performance. Burnout has considerable overlap with symptoms of depression and anxiety (Institute for Quality and Efficiency in Health Care, 2012). Several studies from Scandinavian countries have reported the level of burnout among police officers to be lower than other comparison populations (Kop et al., 1999; Martinussen, Richardsen, & Burke, 2007). In terms of prevalence, De la Fuente and colleagues (2013) reported that in a Spanish sample of national police officers, around one-third of officers reported a high level of burnout. Similarly, in 2011 the incidence of self-reported burnout, which was assessed in one thousand AFP police officers, was estimated to be around 27%, which was the lowest level across all Australian jurisdictions (Jakubauskas & Wright, 2012). Studies examining burnout among police personnel who investigate crimes against children have reported surprising lower rates than expected, given that this work involves exposure to highly distressing material. Specifically, the majority (around 75%) of personnel investigating crimes against children are at a low- to moderate risk for secondary traumatic stress and burnout, and most (around 75%) report moderate to high levels of compassion satisfaction (Brady, 2016; Craun & Bourke, 2014; Perez, Jones, Englert, & Sachau, 2010). Although police officers often work in highly demanding environments, this in itself may not be a sufficient driver for burnout. A recent longitudinal study showed that for police officers working in highly demanding environments, the risk for burnout was moderated by access to resources (Hu, Schaufeli, & Taris, 2017). Specifically, increases in burnout were observed among police with chronically low or decreasing access

to resources, whereas conversely, gaining resources in a chronically demanding environment was associated with decreases in burnout (Hu et al., 2017). These findings highlight the importance of contextual and organisational factors in understanding the relationship between police work and burnout.

Suicide

While police officers are commonly referred to as a high-risk group for suicide (Violanti et al., 2009), obtaining prevalence estimates is difficult due to multiple methodological challenges (O'Hara, Violanti, Levenson, & Clark, 2013). Currently, consistent evidence of elevated prevalence rates of suicide among police officers is lacking (Hem, Berg, & Ekeberg, 2001; Stuart, 2008). This highlights the need for more rigorous epidemiological research to better understand links between policing and suicidality. In the meantime, the seriousness of this issue obviously cannot be overstated.

Barriers to care in high-risk organisations

Research examining barriers to care in policing is extremely limited, and there are no Australian studies looking at this topic. Australians were, however, included in an international study of police officers from five countries (US = 838, Canada = 231, UK = 102, Australia = 58, and New Zealand = 57) (Ménard, Arter, & Khan, 2016). Compared to police from the US, Australian officers were less likely to use available mental health services, for the following reasons: lack of anonymity (24%); stigma (17%); not trusting their department (14%); and believing that the services were either ineffective or inadequate (24%). Some caution should be used when interpreting these results, however, due to the small sample-size and possible self-selection bias.

Internationally, a small amount of research has been conducted. For example, in a study by Fox et al. (2012) US police officers participated in a mental health survey. Among those with a mental health condition (i.e. alcohol abuse, PTSD or depression), 46.7% reported having ever accessed a mental health service. Of those who sought services, the largest proportion (35.7%) sought care exclusively outside the department (non-EAP). Non-EAP use was particularly notable for officers screening positive for PTSD and alcohol abuse. Nearly half of those with a mental health condition reported concerns about accessing the EAP provider. Most commonly the concerns were about the confidentiality of those services (35%), potential negative impact on one’s career (16.7%), and stigma associated with accessing services (13.3%) (Fox et al., 2012).

Barriers to care have been investigated comprehensively in current-serving military personnel. Stigma (in terms of both anticipated public stigma and self-stigma), poor recognition of need for treatment, attitudes or beliefs about mental health treatment, preferences for self-management, and logistical and practical factors have all been identified as barriers to care.

Summary

Police work is associated with unique stressors spanning both operational and organisational domains, and the increased frequency of exposure to critical incidents is thought to elevate risk for mental health disorders, particularly posttraumatic mental health problems. Currently, however, evidence that the prevalence of mental disorders is elevated among police officers when compared to both the general population and other low-risk professions is less conclusive. Although we only conducted a limited review, the lack of epidemiological studies exclusively examining policing makes it difficult to form strong conclusions about the relationships between police work and mental health outcomes. As noted above, the Mental Health and Wellbeing Prevalence Study currently underway will shed further light on this important issue. Furthermore, the survey findings for the current review will provide an important benchmark for the AFP going forward.

For the purpose of this review, the available literature has highlighted the importance of considering both operational and organisational factors as sources of stress for AFP staff and has informed the selection of mental health outcomes to be assessed.

Appendix 5: Documentation review

The AFP provided Phoenix Australia with 60 documents of which 39 were strategic and policy documents pertaining to mental health and wellbeing. These documents are listed at the end of Appendix 5. We have grouped the thirty-six relevant documents into three types: 1) overarching strategic documents; 2) Organisational Health Branch documents; and 3) OHS Policy documents and Guidelines. The strengths, weaknesses and gaps that these documents reveal with regard to the current framework in place to support the mental health and wellbeing of AFP staff are outlined below. By necessity, our comments are based only on the documents that we received. We recognise that there may be other relevant documents that were not provided for review.

Overarching Strategic Documents

The AFP has a number of high level overarching strategic documents that collectively provide a comprehensive and well-articulated vision for supporting the mental health and wellbeing of its workforce.

- The Corporate Plan 2016-17, sets out the AFP's key purpose, responsibilities and strategic directions 2017 through to 2020. It includes references to a healthy workforce and acknowledgement of the often difficult and dangerous environments in which their staff work. However it does not specify key targets for improving the mental health and wellbeing of employees. Safety and wellbeing of staff is included as a risk category in the risk oversight and management sections of the plan, but there are no explicit details about how the safety and wellbeing of staff are prioritised or managed.

- The Draft AFP Mental Health Framework and Mental Health Strategy are forward planning documents that articulate a comprehensive and evidence informed approach to managing and supporting the mental wellbeing of all employees into the future (2016 to 2022). *The Mental Health framework* is a well written, high level document, endorsed by the commissioner via a forward and has a focus on organisational health. It references current best practice guidelines, strategic planning documents and policy documents prepared by national and international agencies that are leaders in the field of organisational mental health and wellbeing and provides an overview of the current mental health needs of its workforce by analysing Comcare data and utilisation of EAP and Psychological Support Services. Importantly, the framework provides a strong message on the importance of preventing mental health issues which is encapsulated within the goals of being `Ready to Act' (increase psychological preparedness) and ` Able to Sustain' (build psychological resilience of individuals and organisation). Four core objectives have been set and include: 1. Mental Health is valued as a priority by AFP leadership, which is proactively dedicated to mental health and its incorporation into all aspects of AFP business. 2. Promotion and prevention strategies are implemented that enables all AFP staff to have knowledge and skills to build their psychological and emotional strengths. 3. Build psychological potential through a collaborative approach,

expert advice and comprehensive and integrated mental health services. 4. Strengthen information systems, resourcing and policies for mental health. Some broad key performance indicators for each of these are provided. *The Mental Health Strategic Action Plan* describes the initiatives that will be undertaken to achieve the objectives and goals of the framework. It describes interventions covering promotion, prevention, early intervention and tertiary prevention and identifies timeframes and costs involved for each initiative. This document is still evolving. The initiatives described are sound and appropriate to the objectives but at this stage are incomplete. Some initiatives have not yet been given a timeframe for completion or been costed and no details are provided around how each of the initiatives might be implemented. It is difficult therefore to determine what the final version of the strategy might look like and whether it will adhere to best practice. For example there is no detail around the specifics of prevention/early intervention programs that might be implemented. Critical questions such as the following, remain unanswered. What prevention/resilience training will be provided? What first and second level interventions will be made available and who will deliver them? What form will the peer support program take? Further, the proposed funding allocation to Psychological Support Services to implement and manage the strategy seems well below what might be required.

- Mental Health Strategy Board: This document briefly describes the composition of the Mental Health Strategy Board, the board's role, intent and terms of reference. The primary role of the board is to shape the AFP's Mental Health Strategy. Although many of the functions of the board are administrative there should be mental health input. As such, it is of note and of some concern that no mental health personnel from the Psychological Support Services team are represented on the board.

- The 2016 report by Elizabeth Broderick (the former Sex Discrimination Commissioner) entitled Cultural Change: Gender Diversity and Inclusion in the AFP is a 104 page document that reports on the findings of a six month review into AFP culture and diversity with a focus on gender. It identifies six principles for improving cultural diversity and respect for diversity within the AFP and outlines a series of recommendations for each of these. The areas covered include leadership; talent promotion; increasing the number of women; flexible work practices; sexual harassment; abuse and bullying; resourcing; monitoring and evaluation. Whilst the document does not have a focus on health or mental health per se it addresses a number of issues that can contribute to stress and undermine mental health wellbeing in the workplace.

- Road2Ready – Physical Health Concept Paper 2017-2020. This is an 18 page document that lays out a model for improving the physical health of the AFP workforce and reducing the costs associated with poor health and injury. The model identifies that there are differing health requirements of AFP staff from recruitment through to retirement and across different roles, and introduces the concept of functional capacity standards to operationalise these differing health requirements. Four `pillars of health' physical,

psychological, rehabilitation and community health have been identified to help guide the focus of key health requirements and interventions at different phases throughout the employees' life cycle. It links increased physical health to reduced burnout and better psychological resilience as well as lifecycle robustness. The model and implementation plan has been developed around six key recommendations and is described as "*an evidence-based, best practice model for a co-ordinated and comprehensive set of health promotion and protection strategies"* with its aim being to '*change the health concept from `sickness' to health and rehabilitation for all injury types."* It is proposed that the model will be implemented over the next 3 years. This approach is consistent with best practice and provides an excellent framework for developing appropriate and effective policies and procedures to enhance the mental health and wellbeing of staff.

- The AFP Leadership Philosophy: this document outlines a leadership model based on the Australian and New Zealand Police Leadership Strategy. It describes the core elements of leadership, core capabilities expected in leadership and the core values of the AFP which are expected to drive the practice of leadership. The need to treat everyone with respect and fairness and to ensure the health and wellbeing of self and others are included as core capabilities. The document provides a blueprint for what is expected of AFP staff in leadership roles, however there is no direct reference to policies and procedures that might help to operationalise the capabilities and it is unclear how staff may be held accountable to them.

- The AFP Cultural Reform – Diversity and Inclusion Strategy 2016-2026

This strategic policy document has been developed to guide cultural reform within the AFP towards a more diverse and inclusive workplace, in recognition that a lack of respect for diversity creates a culture where workplace bullying and harassment can grow. The five priority diversity groups are women, Aboriginal and/or Torres Strait Islander Australians, lesbian, gay, bisexual, trans and intersex people, people with disability, and people from culturally and linguistically diverse backgrounds. The document identifies six strategic pillars that will guide diversity initiatives: Engaging with the workforce; developing inclusive leaders; challenging traditional workplace practices; building a learning organisation; supporting victims and workplaces; and acting on harmful workplace behaviour. High level short term (end of 2017) and long term (varying between end of 2018 to end of 2026) goals are specified, however this document does not drill down to the level of specific action plans.

- Our Culture Our AFP

This is a brief undated document (possibly a pamphlet or PowerPoint presentation) outlining progress towards cultural reform following the launch of the Cultural Reform strategy.

- AFP Diversity Employee Networks

We were provided with information (possibly an AFP Hub entry) detailing the four AFP diversity employee networks: the National Women's Advisory Network; the Malunggang Indigenous Officers' Network; the Gay and Lesbian Liaison Officer network; and the AFP Ability Advisory. These networks are intended to advance diversity and inclusion within the AFP.

Summary: These overarching documents reflect that the AFP has a well-developed understanding of the risk and protective factors that contribute to mental health and wellbeing of the workforce at least at the executive level, and an intention to implement best practice approaches to ensure a psychologically healthy workforce.

Organisational Health Branch

The Organisational Health Branch chart indicates that the Division is comprised of 3 streams: Medical Services (MS) that includes medical services, health and fitness and organisational health admin; Psychological Support Services (PS) consisting of a Principal Psychologist and 8 staff s (5 psychologists, 2 social workers and a family support officer); and Work Health and Safety Rehabilitation (WHSR, comprising three sections – work health and safety, compliance and injury management).

A document entitled *Work Health Safety and Rehabilitation Service Strategy and Business Plan 2015/16* and another policy document entitled '*Work Health Safety and Rehabilitation – Recognition and Organisational Health IRSM Service Policy* spell out a service charter for the Work Health Safety and Rehabilitation division including service standards, values and KPI's for the three areas of WHSR (Work Health Safety, Rehabilitation and Compliance). Their duties include amongst other things helping functional areas develop risk assessment protocols and hazard registers, providing advice on risk management, conducting workplace incident investigations and overseeing and facilitating rehabilitation processes. The plan is based on a new Integrated Regional Service Model launched in 2015 designed *to "eliminate duplication in the delivery of support services to regions". "A single support team has been established in each region drawing on staff from the regional office and the airport. The Regional Support Team operates under the Regional Support Lead".* The model was designed to meet the legislative requirements under the Work Health and Safety Act 2011 and the Safety Rehabilitation Compensation Act 1988. The only policy document of relevance to these areas was the *Better Practice Guide Organisational Health File Access Policy* that describes how Work Health and Safety Advisors and Rehabilitation Case Managers can access and disclose health information collected and stored within the AFP Safety and Protocol Branch. There were no other policy or procedure documents accompanying the business plan that indicates how the WHSR strategy is operationalised in the workplace and no evaluation report indicating performance against KPI's were provided. Nevertheless, the strategy is comprehensive and would appear to meet at least the minimum requirements of providing an effective work, health safety and rehabilitation service to AFP staff.

There were no documents that describe the charter or business strategy for the Medical Services teams or Psychological Support Services. It is therefore unclear what roles they play, what their governance and accountability framework might be, what their model of care might look like and how AFP staff might be referred to and use their service. However, the Mental Health Framework document does provide an indication of the types of services that PS offer by giving a snapshot of the pattern of usage of their services in 2014-15. PS time was spent as follows: work clearances (27%); mental health assessments (11%); consulting on mental health issues (10%); family member contacts by the family services officer (9%); advice to management (8%); debriefs (7%); bullying and harassment complaints (4%); response to critical incidents (3%); vocational issues (3%); personal issues (2%); disciplinary action (2%); work related trauma (1%); psychological issues relating to physical health (1%); and equity and diversity, selection and specialist assessment (0.3% combined). The organisational chart provided would suggest that three of the Psychology Services positions are currently vacant.

There is no mention of the chaplaincy service on the organisational chart and no documentation available that describes the chaplaincy service, how it is accessed, its role and responsibilities, governance etc.

A recently developed document (August 2017) was provided on the Welfare Officer Network. This document includes clear and appropriate delineation of role, responsibilities and boundaries for Welfare Officers. It is noted that clinical support will be provided by "an AFP employee from Organisational Health Branch", however the qualifications required of the person providing clinical support is not specified. A social worker or psychologist would be appropriate. Note is made that by "an AFP employee from Organisational Health Branch", however the qualifications required of the person providing clinical support is not specified. Given their role in attending significant incidents such as the death of a child, appropriate training would include psychological first aid. The relationship between the Welfare Officer Network and the Confidant Network and Safe Place (described under Specific OHS Policy documents and Guidelines below) would benefit from further clarification. The current description in the Welfare Officer Network document is: *"the relationship between the Welfare Officer Network, Safe Place and Confidant Network is one of referral in finding staff the best fit for their concerns."*

A services agreement with the EAP provider Davidson Trahaire Corpsych outlines the terms of their contract including their obligations and services to be provided, which include:

- Counselling
- Conflict resolution
- Training
- Trauma/critical incident management
- Management advice
- Confidentiality

- Reporting
- Quality assurance

The document outlines the qualifications and experience expected of providers. However the list of specified personnel provided does not specify their qualifications and experience. Further, it is unclear whether the list of specified personnel, arranged under the headings of Strategic Contract Management and Advisory Services, National Clinical Management and Service Specialists actually includes the individuals providing direct service to AFP staff. It is unclear whether the EAP providers are appropriately qualified psychologists or social workers with a minimum of five years supervised postgraduate experience. The Agreement specifies appropriate metrics for quarterly reporting on service provision. .

A document entitled `Guide' is a two page document providing a tick box list of administrative requirements for the induction of new staff in organisational health.

Summary*:* The level of documentation provided describing the roles, policies and procedures of the organisational health teams was scant aside from a business plan for the WHSR group and the recently developed Welfare Officer Network document. In the absence of comprehensive documentation that is linked to the overarching mental health strategy, and outlines the range of staff support mechanisms and how they operate together as a coherent package, it is difficult to comment on the capacity of organisational health to meet the mental health needs of the AFP workforce.

Specific OHS policy documents and guidelines

The Enterprise Risk Profile Executive Summary provides a risk matrix and a risk register with a treatment plan. Four categories of risk are identified – Organisational Health and Safety; Operational Outcomes; Resourcing, Workforce Planning & Management; and Support Capability. While all have potential relevance to staff wellbeing we only received the register and treatment plan for Organisational Health and Safety. Item 1.3, Mental health injury to AFP personnel, has a rating of high – seen as likely to happen and having major consequences. The treatment plan for this item identifies 5 treatments which are rated as being on track for completion. These include resourcing to meet mental health first aid and suicide prevention training needs, cultural change review action items, increased OH involvement in leadership development and health monitoring (this one is rated as progressing but behind schedule). Additional detail on what these `treatment plans' involve, and how they are to be implemented would be helpful in determining their adequacy.

With the exception of a policy on the viewing of child exploitation material, there were no documents provided that spell out the specific psychological risks associated with different high risk work areas or specific risk management plans to address these.

The Commissioner's Order on Professional Standards details the expectations regarding the conduct of AFP staff, with respect to core values, codes of conduct, and compliance with governance instruments. The Order also outlines obligations for reporting contraventions of

professional standards on the part of other AFP staff and complaint management methodology and processes. Reference is made to the AFP Categories of Conduct Determination 2013 which delineates three Categories of misconduct: Category 1 includes minor misconduct issues related to minor management, performance or customer service issues; Category 2 includes repeated Category 1 misconduct or breaches of the Code of Conduct, National Guidelines or Commissioners Orders; and Category 3 comprises serious misconduct issues including serious breach of law, serious breaches of Commissioner's Orders, National Guidelines or the Code of Conduct. Corruption is a separate category again.

A range of *National Guideline documents* and *Better Practice Guides* that have been developed under the `Professional Standards Framework' were provided. These are detailed, structured managerial documents that provide general guidance on addressing particular work practices and professional conduct issues at a national level and spell out the roles and responsibilities of different staff in relation to specific tasks or work practices. The following documents specifically relate to OHS practices and staff wellbeing:

- *The Better Practice Guide on Emergency Procedures* defines the roles and responsibilities of positions with the emergency management infrastructure, ensures that appropriate emergency management infrastructures are established and maintained, assigns the responsibility for emergency procedures in AFP business areas and identifies training to maintain efficient emergency management infrastructures. Although reasonably comprehensive there was no documentary evidence of how well this guide is implemented in business areas and regions. There is no specific mention of psychological hazards and risks in the document or how psychological injury may be dealt with.

- *The National Guideline on Critical Incidents* acknowledges the importance of welfare support and management of psychological wellbeing following critical incidents. It provides appropriate guidelines for managing wellbeing support following a critical incident. There is no indication that the Guideline is differentially applied across regions or operational areas, and no consideration given to managing the impact of cumulative trauma exposure. Reference is made to two additional documents which were not sighted, Incident and Command Control System Plus (ICCS) and Wellbeing Services Notification Protocols. The latter one in particular would be useful to determine whether there is clarity around what triggers a referral to wellbeing support services.

- *AFP National Guideline on Health and Safety Management Arrangements:* This document describes the AFP's obligations under the health and safety management arrangements including outlining the work health and safety responsibilities; establishing the health and safety consultation framework; providing the process for dispute settlement and documenting the agreed arrangements to ensure the health, safety and welfare of workers.

- *AFP National Guide on Risk Management.* A well written policy document that outlines the roles, responsibilities and obligations of different staff groups, as well as policies and procedures (albeit at a reasonably high level) for a common approach by all AFP staff to managing risks that may impact on the AFP achieving its objectives. It describes a sound process for measuring effectiveness.

- *The Better practice Guide on Managing Work Health and Safety Risks* outlines the legislative and AFP requirements for workplace health and safety risk management when applying the *AFP National Guideline on risk management.* It assists with the application of WHS risk management principles to identify, assess, control, and review any foreseeable hazards that may have potential to affect the health or safety of workers; and identifies the risk management responsibilities for persons at the workplace over which they have influence and control. The document is detailed and practical and does cover the identification of psychological hazards, however again there is no visibility as to how the document is translated and applied in individual work or business areas.

- *The Better Practice Guide to Reporting Workplace Incidents and Hazards* details reporting responsibilities and processes for incidents and hazards in the workplace. While the Guide refers to physical and psychological injury, there is no definition provided of psychological hazards or psychological injury. These would be useful additions.

- *The Better Practice Guide to Conducting Workplace Incident and Hazard Investigations* details the processes for conducting a root cause analysis (RCA) following an incident or hazard identification. The Guide defines injury as physical or psychological but does not elaborate on these or otherwise refer specifically to psychological hazards or injuries.

- *AFP Workplace Incident Report:* A template for reporting workplace incidents – allows for recording of physical injuries but psychological injury not mentioned.

- *The AFP National Guideline on the Confidant Network*: outlines the role and obligations of the Confidant Network (CN), confidants, the Confidant Network Coordination Team (CNCT) and other staff in managing Confidant Network referrals. The Confidant network provides information, options and support to staff when dealing with inappropriate or unethical behaviour in their work environment. Training is provided to confidants but the role is voluntary and in addition to normal role. No information is provided on selection criteria for confidants.

- *Safe Place:* We were provided with an AFP Hub post that describes Safe Place as providing support and advice to staff who are experiencing, have experienced or are aware of sexual assault, sexual harassment, serious bullying and harassment within or connected to the workplace. Information about the qualifications or training of Safe Hub case workers was not included.

- *The AFP Practical Guide on Wellbeing Support for Members dealing with Explicit Material and AFP National Guideline on Managing Child Exploitation Material.* These two documents provide guidance on minimising the risks associated with viewing of objectionable material, recommends regular psychological screening; and describes the role of `hot debriefs' and how explicit material should be managed and stored. It would make sense to combine these into one document as they are incomplete and inadequate as stand alone documents.

- *AFP National Guideline on medical, psychological and physical competency:* This guideline outlines the obligations for AFP staff for undergoing medical, psychological and physical competency assessments as part of their ongoing readiness or fitness for duty.

- *Statement of Inherent Requirements from a Health Perspective for AFP Sworn Policing and Protective Service Officer Roles.* This documents list the inherent health requirements (Physical, cognitive, sensory and perceptual, communication, behavioural and emotional and strength and mobility) that all AFP staff must have in order to perform their roles. It includes a range of resilience factors and mentions the ability manage exposure to emotional distress, emotional intelligence concepts, adaptability etc. It does not say how these capacities are measured or monitored.

The following documents relate specifically to professional conduct issues.

- National Guideline on Integrity Reporting

- National Guideline on Complaint Management.

These documents outline how complaints should be handled within the AFP and what the formal integrity reporting requirements are. Neither documents refers to health, mental health or stress. To the extent that the handling of minor complaints (category 1 or 2) relies on the subjective determination of the recipient of the complaint in the first instance to determine its veracity and resolve it, the process can run the risk of potentially being misused in instances where there maybe undisclosed conflicts of interest. The National Guideline on Integrity Reporting provides a list of reporting requirements that includes "*being served with a diversionary conference note, by any law enforcement body, to attend education, assessment and treatment or counselling relating to any matter (where there has been no arrest or charge)*". This would be appear to raise issues of confidentiality particularly if the recommendation pertains to mental health issues.

Training documents

- *Introduction to Professional Standards:* This is a well-developed training program covering key professional standard areas such as core values, code of conduct, integrity reporting, workplace conflict, secondary employment, driving under the influence, conflict of interest, social networking and mandatory reporting. It provides a summary of each

area followed by case scenarios and a series of multiple choice options with a description of potential outcomes for each. It provides links to the national guidelines, legislation or other policy document that exist on each topic.

- *Workplace Bullying:* This is a well-developed training program that defines bullying and harassment how they impact on people's wellbeing. It then posits a number of case scenarios and asks the participant to determine on face value if it could be seen as bullying or harassment or reasonable management action. It then describes how to report incidents of bullying or harassment both internally and externally and provides a list of support networks (internal and external to the AFP) giving a description of each, what support they can provide and a contact number.

- *Work, Health and Safety:* This training is designed to educate staff on the legislative changes to the WHS act and how WHS works in the AFP. Interestingly it reports that 891 incidents were reported in 2014 but not one is listed as a psychological injury. 135 claims were accepted at a total cost of $18.4 million. The training goes through in detail the policies and procedures involved in risk assessment, risk management, incident reporting and incident management and the roles and responsibilities of different staff in the process. It also explains the compensation act, how it is applied, the process for accessing compensation, the right of appeal, what will be paid for, time off work etc. It also walks the participant through the rehabilitation process and return to work procedures. Finally it goes through workstation (including vehicles) setup and proper use. The program has interactive exercises and provides links to relevant policies, procedures and legislation. Unfortunately it has a heavy focus on physical risks with very little attention paid to psychological risk identification and risk management and psychological injury reporting and management.

Summary: There are some well written and detailed policy documents particularly around risk assessment and risk management (at a national level), but very little around how to deal with a psychological injury or manage the impact of potentially traumatic events. There were no regional specific or business area specific documents that might tailor the national risk assessment and risk management, emergency procedures and managing critical incidents policy documents to the areas specific needs.

The training programs on Professional Standards and Bullying were well developed. The Work Health and Safety training program does not cover psychological risks and injury in any detail. It would appear that whilst the high level strategic documents provide a solid foundation for developing and implementing a comprehensive wellbeing program within AFP, at this stage there is little in the way of detailed policy and procedural documents that might serve to operationalise this strategic vision.

List of documents received by Phoenix Australia from AFP

	DOCUMENT TITLE	In scope?	Used for
1.	AFP National Guideline on Critical Incidents	Yes	Document review
2.	AFP National Guideline on Complaint Management	Yes	Document review
3.	AFP National Guideline on integrity reporting	Yes	Document review
4.	AFP National Guideline on Managing Child Exploitation Material	Yes	Document review
5.	AFP National Guideline on the Confidant Network	Yes	Document review
6.	AFP National Guideline on health and safety management arrangements	Yes	Document review
7.	Enterprise Risk Profile Executive Summary	Yes	Document review
8.	Broderick report 2016 – Cultural Change: Gender diversity and Inclusion in the AFP	Yes	Document review
9.	Corporate Plan 2016-17 to 2019-20	Yes	Document review
10.	Organisational chart 6.3.17	Yes	Understanding organisational structure and function
11.	Mental Health Strategy – Discussion paper	Yes	Document review
12.	MH Framework 2016 – 2022	Yes	Document review
13.	MH Strategic Action Plan 2016 – 2022	Yes	Document review
14.	Weblinks to AFP annual reports https://www.afp.gov.au/about-us/publications-and-reports/annual-reports	No	Background information
15.	Web links to governance legislation https://www.afp.gov.au/about-us/governance-and-accountability/relevant-legislation	No	Background information
16.	Better Practice Guide for Organisational Health File Access Policy	Yes	Document review
17.	Better Practice Guide for Reporting Workplace Incidents ad Hazards	Yes	Document review

18.	Better Practice Guide for Conducting Workplace Incident and Hazard Investigations	Yes	Document review
19.	Road2Ready – Physical Health Concept Paper 2017-2020	Yes	Document review
20.	AFP National Guideline on medical, psychological and physical competency assessments	Yes	Document review
21.	AFP Practical Guide on Wellbeing Support for Members Dealing with Explicit Material	Yes	Document review
22.	Organisational Health New Starters Guide	Yes	Document review
23.	Services Agreement 2015 – 18 with EAP provider Davidson Trahaire Corpsych	Yes	Document review
24.	Work Health Safety& Rehab: Recognition & Organisational Health IRSM Service Policy	Yes	Document review
25.	WHS&R Service Strategy & Business Plan 2015-6	Yes	Document review
26.	Statement of Inherent Requirements from a Health Perspective for AFP Sworn Policing & PSO Roles	Yes	Document review
27.	AFP Hazard Register	Yes	Document review
28.	iAspire Training Workplace Bullying	Yes	Document review
29.	iAspire Training – Work Health and Safety	Yes	Document review
30.	iAspire Training – Introduction to Professional Standards	Yes	Document review
31.	Keeping it real policy paper _ Orygen	Yes	Consideration in recommendations
32.	Better Practice guide on managing work, health and safety risks	Yes	Document review
33.	National Guide on Risk Management	Yes	Document review
34.	Better Practice Guide – Emergency Procedures	Yes	Document review
35.	AFP Workplace incident reporting form	Yes	Document review
36.	Crime Ops Organisational Structure	Yes	Understanding organisational structure and function
37.	AFP Leadership Philosophy	Yes	Document review
38.	Canberra Times Article 22/05/2017	Yes	Context for review

39.	PIVOT NSW Police Return to Work presentation	Yes	Consideration in recommendations
40.	Web links to mental health training for managers (Beyond Blue) https://www.headsup.org.au/training-and-resources/news/2017/04/27/new-free-online-learning-module-helps-manage-mental-health-risks	Yes	Consideration in recommendations
41.	Email providing information on the AFP Diversity Employee Networks	Yes	Document review
42.	Stuart, T., & Amy, W. (2017). A focus for mental health training for police. Journal of Criminological Research, Policy and Practice. doi: 10.1108/jcrpp-01-2017-0005 Focuses on mental health training for police officers to support community members, not colleagues	No	N/A
43.	Information about Andy Cullen, PTSD survivor and coach	No	
44.	Email from staff member about private provider	No	
45.	Email from staff member with links to “Depression Let’s talk program”	No	Background information
46.	Policy document from NCIS Peer Support Program	Yes	Consideration in recommendations
47.	Email from staff member with web links to corporate wellbeing program: http://www.healthymindsprogram.com.au/corporate-program	No	Background information
48.	Job demands resource stress model – PowerPoint slide	No	Background information
49.	Carfi Psychological and Rehabilitation Services PDF copy of presentation on preventing psychological injury in the workplace	No	Background information
50.	Information about the Road to Mental Readiness	Yes	Consideration in recommendations
51.	Information about Tema Center Memorial Trust	Yes	Consideration in recommendations
52.	Peer Support and Crisis-Focused Psychological Intervention Programs in Canadian First Responders: Blue Paper	Yes	Consideration in recommendations

53.	Victoria Police Mental Health Review May 2016	Yes	Consideration in recommendations
54.	Information forwarded by AFP staff member about Michelle Kafer Workforce Development	Yes	Consideration in recommendations
55.	Mental Health Strategy Board	Yes	Document review
56.	AFP Diversity and Inclusion Strategy	Yes	Document review
57.	Our culture our AFP Pamphlet or Presentation	Yes	Document review
58.	Screenshot of Safeplace hub webpage	Yes	Document review
59.	The Australian Federal Police Commissioner's Order on Professional Standards	Yes	Document review
60.	Better Practice Guide for the Welfare Officer Network	Yes	Document review

Appendix 6: Invitations to attend staff focus groups and family teleconference

Focus group invitation

Mental Health Focus Groups – Phoenix Australia Review of Mental Health in the AFP

Phoenix Australia Centre for Posttraumatic Health, affiliated with the University of Melbourne, is currently undertaking a review into mental health within the AFP, with work being used to inform an enhanced AFP Mental Health Strategy.

Phoenix have commenced with their internal review of literature and governance, with planned one-on-one interviews and a series of focus groups to take place during May 2017. An information sheet on Phoenix Australia's work with the AFP is attached for your reference.

To book into a Focus Group in [Western Australia], please click on the following link:

https://www.gobookings.com/au/clients/04271718056891

There are a number of Focus Groups to choose from. Participation is capped at 15 for each session.

Focus groups for other locations around Australia are currently being advertised.

Phoenix have also facilitated an independent email address for AFP staff to use for engagement with Phoenix and contribution to the review. AFP staff can send email enquiries to AFP-mentalhealthreview@unimelb.edu.au.

All other queries can be directed to Nicola Todd, Project Officer for Mental Health, at AFPMentalHealthStrategy@afp.gov.au.

Attachment 1 : Phoenix Australia Information Sheet for staff focus groups

Australian Federal Police Mental Health Review

What is the review about?

The Australian Federal Police (AFP) has asked Phoenix Australia - Centre for Posttraumatic Mental Health to undertake a review of the organisation's approach to mental health services and systems, and to make recommendations for improvement.

Focus Group Phase

As part of this initiative, Phoenix Australia will be conducting focus groups with AFP staff across Australia. The focus groups will be used to gather perspectives and opinions on:

- Workplace factors that impact on staff wellbeing
- Current approaches to supporting the wellbeing of staff within AFP
- The accessibility, effectiveness and barriers to support service uptake.

What is involved in the consultations process?

Two staff members from Phoenix Australia will conduct each focus group. There will be up to 20 AFP staff in each group. The focus groups will involve a broad discussion about your role and experience in the AFP, specifically with regard to mental health risks in the workplace. Your views on the support available for mental health and wellbeing will also be sought.

Details of focus group times and locations can be found on the following page.

Please take this opportunity to book into a focus group in your area and have your views heard.

What will happen to my information gathered from the consultation?

The information will be used to inform recommendations for the AFP Mental Health Review. These recommendations will be delivered as a report.

Individual responses to questions or comments will not be identified in any communication to AFP management or in the report.

Who is Phoenix Australia - Centre for Posttraumatic Mental Health?

Phoenix Australia – Centre for Posttraumatic Mental Health is a not-for-profit organisation, affiliated with the University of Melbourne, dedicated to reducing the impact of trauma by building the capability of individuals, organisations and the community to understand, prevent and recover from the adverse mental health effects of trauma.

Schedule of focus groups

State	Office	Date	From	To
ACT	ACT Policing	Thu, May 4 2017	9:00 AM	10:30 AM
ACT	ACT Policing	Thu, May 4 2017	11:30 AM	1:00 PM
ACT	ACT Policing	Thu, May 4 2017	2:00 PM	3:30 PM
ACT	Barton College	Tue, May 30 2017	11:30 AM	1:00 PM
ACT	Barton College	Tue, May 30 2017	2:00 PM	3:30 PM
ACT	Cbr Airport	Fri, May 19 2017	2:00 PM	3:30 PM
ACT	Cbr Airport	Thu, May 4 2017	2:00 PM	3:30 PM
ACT	Headquarters	Fri, May 5 2017	9:00 AM	10:30 AM
ACT	Headquarters	Fri, May 5 2017	11:30 AM	1:00 PM
ACT	Headquarters	Tue, May 30 2017	9:00 AM	10:30 AM
ACT	Majura	Fri, May 19 2017	9:00 AM	10:30 AM
ACT	Majura	Fri, May 19 2017	11:30 AM	1:00 PM
NSW	Sydney Airport	Wed, May 24 2017	12:15 PM	1:45 PM
NSW	Sydney Airport	Wed, May 24 2017	2:30 PM	4:00 PM
NSW	Sydney Office	Tue, May 23 2017	12:15 PM	1:45 PM
NSW	Sydney Office	Tue, May 23 2017	2:30 PM	4:00 PM
NSW	Sydney Office	Tue, May 23 2017	9:45 AM	11:15 AM
NT	Pine Gap	Wed, Jun 7 2017	10:15 AM	11:30 AM
NT	Darwin Airport	Mon, Jun 6 2017	2:00 PM	3:30 PM
QLD	Brisbane Airport	Thu, May 18 2017	8:30 AM	10:00 AM
QLD	Brisbane Airport	Tue, May 16 2017	9:00 AM	10:30 AM
QLD	Brisbane Office	Thu, May 18 2017	1:00 PM	2:30 PM

QLD	Brisbane Office	Thu, May 18 2017	10:30 AM	12:00 PM
QLD	Brisbane Office	Thu, May 18 2017	8:30 AM	10:00 AM
QLD	Cairns Airport	Wed, May 17 2017	2:00 PM	3:00 PM
QLD	Gold Coast Airport	Tue, May 16 2017	2:00 PM	3:00 PM
SA	Adelaide Airport	Tue, May 30 2017	1:30 PM	2:45 PM
SA	Adelaide Office	Tue, May 30 2017	11:00 AM	12:15 PM
SA	Adelaide Office	Tue, May 30 2017	9:30 AM	10:45 AM
VIC/TAS	Melbourne Airport	Fri, May 26 2017	11:30 AM	1:00 PM
VIC/TAS	Melbourne Airport	Fri, May 26 2017	2:00 PM	3:30 PM
VIC/TAS	Melbourne Office	Fri, May 26 2017	9:00 AM	10:30 AM
VIC/TAS	Melbourne Office	Fri, May 26 2017	11:30 AM	1:00 PM
VIC/TAS	Melbourne Office	Fri, May 26 2017	2:00 PM	3:30 PM
WA	Exmouth	Wed, May 10 2017	9:00 AM	10:30 AM
WA	Geraldton	Thu, May 11 2017	10:45 AM	12:15 PM
WA	Perth Airport	Tue, May 9 2017	10:30 AM	12:00 PM
WA	Perth Office	Tue, May 9 2017	1:00 PM	2:30 PM

If you are unable to attend a focus group or if you have additional comments to make, you may email us at AFP-mentalhealthreview@unimelb.edu.au . Information gathered will be reported in aggregate form, ensuring that the confidentiality of individuals is preserved. All information received by the end of May 2017 will be considered as part of the review.

Family Teleconference Invitation

Call for Family Input: AFP Mental Health Review

Dear Colleagues,

The Australian Federal Police has asked Phoenix Australia to undertake a review of the organisation's approach to mental health services and systems, and to make recommendations for improvement.

As part of this initiative, Phoenix Australia will be conducting telephone interviews with the families of AFP staff on 1st and 2nd June 2017. The interviews will be used to gather perspectives and opinions on:

- Workplace factors that impact on staff wellbeing
- Current approaches to supporting the wellbeing of staff within AFP
- The accessibility, effectiveness and barriers to support service uptake

Please share the attached information sheet with your families, so that they may consider contributing to this important review.

If family members wish to participate in a teleconference or if they have additional comments to make, they may email Phoenix Australia directly at AFP-mentalhealthreview@unimelb.edu.au. A toll free teleconference number will be provided upon booking confirmation.

Further information on Mental Health in the AFP can be directed to AFPMentalHealthStrategy@afp.gov.au.

Attachment 2: Phoenix Australia Information Sheet for family teleconferences

Australian Federal Police Mental Health Review

What is the review about?

The Australian Federal Police (AFP) has asked Phoenix Australia - Centre for Posttraumatic Mental Health to undertake a review of the organisation's approach to mental health services and systems, and to make recommendations for improvement.

Family Teleconference Phase

As part of this initiative, Phoenix Australia will be conducting a series of teleconferences with family members of AFP staff across Australia. The teleconferences will be used to gather families' perspectives and opinions on:

- Workplace factors that impact on staff wellbeing
- Current approaches to supporting the wellbeing of staff within AFP
- The accessibility, effectiveness and barriers to support service uptake.

What is involved in the teleconference?

Two staff members from Phoenix Australia will conduct each teleconference. There will be up to 8 AFP family members in each group. The teleconference will involve a broad discussion about your experience of having a family member in the AFP, and in particular, your perceptions of mental health risks in the workplace. Your views on the support available for mental health and wellbeing will also be sought.

Details of teleconference times and call-in details can be found on the following page.

Please take this opportunity to book into a teleconference and have your views heard.

What will happen to my information gathered from the teleconference?

The information will be used to inform recommendations for the AFP Mental Health Review. These recommendations will be delivered as a report.

Individual responses to questions or comments will not be identified in any communication to AFP management or in the report.

Who is Phoenix Australia - Centre for Posttraumatic Mental Health?

Phoenix Australia – Centre for Posttraumatic Mental Health is a not-for-profit organisation, affiliated with the University of Melbourne, dedicated to reducing the impact of trauma by building the capability of individuals, organisations and the community to understand, prevent and recover from the adverse mental health effects of trauma.

Schedule of Teleconferences May 2017

Thursday 1st June

Time	**Family Member's Operational Role**
9.00 – 10.00 am	Investigations and Prevention
10.30 - 11.30 am	Community Policing
12.00 - 1.00 pm	Protective Services
2.00 - 3.00 pm	International Police Assistance
3.30 – 4.30 pm	Criminal Asset Litigation

Friday 2nd June

Time	**Family Member's Operational Role**
9.00 – 10.00 am	Liaison and Partnership
10.30 - 11.30 am	Forensics
12.00 - 1.00 pm	Specialist Capabilities (including intel, surveillance, tactical operations, covert)
2.00 - 3.00 pm	Corporate services

Appendix 7: Key themes from the consultations

The consultation component of the review involved interviews with the senior executive (SES), Organisational Health Division, all-staff focus groups, individual interviews with individual members (upon request), family members and written submissions. The themes presented below reflect messages we heard repeatedly throughout the consultations across all levels of the organisation.

The key themes derived from the interviews and focus groups are presented first, followed by themes reported in the family teleconferences and finally the written submissions.

Member interviews and focus groups

Theme 1: Positive aspects of the job

Across the organisation members consistently identified a number of positive aspects of working with the organisation. Interestingly, positive themes were largely consistent across both sworn and unsworn/professional roles, and include:

- Good work conditions (i.e. pay and leave)
- Family friendly
- Parts of the job that are stressful can also be the exciting/rewarding parts
- Variety of the work
- Helping the community
- Pride in their role as a police officer (distinct from levels of pride in the AFP)
- Opportunity to ‘make a difference’
- Being part of a team / and ‘extended family’
- Job stability

The dedication and commitment of staff to the organisation and its mission was noteworthy.

Theme 2: Perception of change for the better

- Recognition that senior leadership, especially the Commissioner, is genuinely committed to change in culture, attitudes and practices; many comments that this change has come about with the current Commissioner, turning around the previous poor morale
- Grant Edwards’ willingness to be open about his mental health problems, and the organisational support for that, was seen as a major step forward (Note: this view was by no means universal – see below, Theme 9)
- Readiness for change, desire for clear leadership to take them in the right direction
- Responses to recent issues (e.g., cultural reform) are seen as positive and bringing the organisation in line with the broader community

- High level of recognition of the importance of mental health

Theme 3: The pace of change and commitment to sustainability

- There is some concern that too much is happening too quickly – many new initiatives are coming across people's desks (e.g., cultural reform, future directions, mental health).
- Cynicism about whether these initiatives actually mean anything; seen as being characteristic of AFP reacting quickly to be 'seen' to be doing something without thinking it through or being truly committed to the outcome – consistently described as a 'reactive organisation'.
- *"The AFP is characterised by rhetoric and inconsistency."*
- *"Stop the gender panic."* There were concerns that rapid changes to promotion and recruitment practices favouring female staff generates resentment in males refused promotion and concern among women that they are being promoted because of gender rather than merit.
- Concern about whether all these new initiatives are sufficiently integrated to become embedded and sustainable.

Theme 4: Manager capability

- Recognition that there are some great managers at all levels (i.e., in terms of leadership, people management skills, and mental health awareness) but there are also many who are not good. There is a strong desire for greater consistency in this area.
- Managers who excel in people management skills need to be supported to allow them to become champions for cultural change.
- Need for effective training for all people going into supervisor/management positions; specific training in areas such as leadership, people management, mental health awareness should be successfully completed before someone can apply for promotion to supervisory/management positions. Currently, people are typically promoted to management for operational skills, rather than leadership skills.
- Need for ongoing mentoring/support in management skills.
- Clear KPI's in people management areas, and these skills should be major criteria for promotion. KPIs could include, for example, absenteeism rates and 360 evaluations as part of promotion process.
- Need a clear set of AFP values that are not seen as just rhetoric. All staff members are held to account to these values.
- Specific attention needs to be given to developing people skills in team leaders and supervisors in overseas deployments. These supervisors experiences lots of pressure to support teams in absence of any additional welfare services.
- Recent introduction of "Assessment Centres" for selection of team leaders and above is widely seen as a good move; request for increased mental health focus (e.g., managing a staff member with mental health problems in role plays and scenarios).

Theme 5: Performance management and career development

- Widespread concern about the organisations' ability to manage poor performance; perception that difficult staff are often just moved to another area ("packaged for export").
- Middle managers feel unsupported, especially when dealing with poor staff performance. Managers are also perceived by their staff as being ill-equipped to deal with performance management issues.
- Perception that lots of support is provided to the staff member undergoing performance management. This is often seen as a risk management strategy or damage control in case of bullying accusations. Little support is provided to the managers struggling to deal with the situation.
- Requests for help/support (e.g., from Psychological Support Services to deal with a staff member who has mental health issues) are ignored or result in criticism (e.g., being called a "dinosaur").
- Wide-spread concern that the Performance Development Appraisal (PDA) system is not taken seriously and is not effective in managing poor performance or in recognising and rewarding good performance, it is just seen as ticking the box for HR.
- Members commented that the organisation did not always deliver on promises made at recruitment. For example, a number of staff reported that they were advised that they might spend the first few years in less desirable locations/roles before being moved, while in reality, they often felt stuck indefinitely in undesirable locations/roles. Members requested clear and realistic communication at recruitment about what they can expect from the organisation.

Theme 6: Cultural identity

- Many members saw differences in the organisation along the following lines:
    - Geographical locations: Canberra, regions, remote locations
    - Work roles: National office roles (e.g., Joint Anti Child Exploitation Team (JACET), Counter Terrorism, Intelligence, aviation, protective services, ACT police
    - Type of employee: "True Blue" AFP vs "laterals" (moved to AFP from state police) vs ex-PSO's vs current PSO's; sworn vs unsworn.
    - Senior executive, middle management, frontline members
- Members see that developing a shared cultural identity is important, but it is not without challenges. There were many comments regarding tensions about "political correctness", "bureaucrats in Canberra" were often seen by officers to push an agenda of political correctness, which some members resented and perceived to be as disrespectful of their professionalism. It was considered important that the differences between locations and operational roles sometimes need to be acknowledged rather than always adopting "one size fits all" solutions.
    - An example of this tension was different attitudes toward the use of "gallows humour" or black humour. When viewed out of context, gallows humour can easily be seen as derogatory and 'politically incorrect'. Some members reported reacting negatively and feeling resentful when directed not to use this coping strategy. They believed that this direction was given because other people in the

organisation (who are not doing the same work as them) find it upsetting. Members perceive a "growing chasm" between senior management and the operational workforce. This was identified by staff as occurring within Head Office (with the Senior Executive "tucked away" on the fifth floor), between Head Office and the regional offices, and within the regional offices.

- In relation to the chasm between Head Office and the regions specifically, repeated concerns were expressed from the regions that Canberra is out of touch, instructions are passed from "on high" made by people who have no idea what real frontline work involves.
- There were frequent comparisons between groups ("we're better than them…they're not real AFP") results in cliques and perceived injustices (i.e., in promotion decisions).
- Staff commented that there are really several different organisations all struggling to fit together as part of the same organisation with shared and separate identities, AFP is referred to as a "platypus".
- Joint task forces (with other agencies) is fraught with difficulty – different rules, regulations, support services, expectations; team leaders are expected to manage people from different agencies. We understood that joint task forces are increasing, and members would like to see these issues proactively addressed by the AFP.
- It was noted by a number of staff that enterprise agreement negotiations for the general workforce are 18 months overdue, (with, in their view, little to suggest the organisation is keen to resolve the new agreement) while the executive agreement was negotiated and signed immediately.
- There were a number of comments suggesting that the current narrative of AFP being 'a family' needs to be changed as it sets up an unrealistic expectation and does not encourage self-reliance or an expectation that individuals can successfully move in and out of the organisation.
- Representation and support by the senior executive (SES) of the diversity networks is seen to be very limited.

Theme 7: Managing budgets, resources and demands

- There were widespread perceptions that budgets are constantly cut, with no associated cuts in what is expected. Staff expressed the view that the executive is not willing to stand up to government – if AFP budget is cut, management should cut service provision accordingly.
- Staff also noted the impact of the historical model of government funding against specific operations with non-ongoing funding, leading to recruitment and redundancies at short notice, and pressure to 'do more with less', particularly for surge or transition activities.
- There were reports that people in some areas (not all) are working long hours just to get work done. This seems to happen particularly in areas or roles that do not have shift work and where there is no one to take over tasks. Other areas complain of working with staff levels that are too low to be safe for operations (e.g., aviation) and contrary to OH&S guidelines.
- Larger regions (especially NSW, VIC) report needing more resources (claims that 75% of AFP "work" – drug busts, organised crime, terrorism, etc – is done in Sydney);

perceptions that state manager in those states should be Assistance Commissioner level (similar model to the FBI in the United States).

- Staff reported a "culture of fear" around the risk of making mistakes, and felt that responsibility is a heavy load when resources are insufficient.
- Concern about increasing layers of bureaucracy, for example, having to complete multiple forms in relation to a single task, which can get in the way of efficient practice.
- Concern among regional members that physical resources outside Canberra are often inadequate; no "relaxing" space to escape to after completing difficult tasks. Physical environment can be poor (no windows/natural light) in contrast to EBB in Canberra.

Theme 8: Inadequacy of current wellbeing supports

- There was widespread confusion about what is available and how to access the support when required. Staff commented that there needs to be greater attention to integration of services as no-one appears to understand how it all fits together. There was a perception that current supports were developed in ad hoc manner without a strategy for how they coordinate and mutually support each other.
- Comment was made that funding for interventions is inconsistent and not transparent. For example, it was reported that some services are provided an annual budget, while others need to be funded out of regional operational business areas.
- It was noted that a number of key staff related areas i.e. HR and some Organisational Health units are not staffed by appropriately trained and/or experienced staff.
- Deep concern was expressed across all levels of the organisation about severe cuts to Psychological Support Services and other potential mental health supports.
- Staff expressed the view that there needs to be a return to regionally based psychological services support, with responsibility for remote areas where applicable, and to increase visibility of these services in the regions through regular visits.
- Regarding members who had undertaken overseas services, there was a perception from some that support is much less than the support provided by other organisations i.e. ADF Others were critical of overall perceived lack of support i.e. lack of acknowledgement of their overseas service and levels of associated risk. Staff expressed a need for much stronger support for overseas personnel, specifically:
    - Better pre- and post- preparation and debriefing (including family reintegration)
    - Meaningful assertive outreach while away (personalised "checking in")
    - Better support for families pre-, during and post- deployment
    - Opportunities for networking and mutual support among members who had also had overseas experience.
    - Appropriate support for leaders of offshore programs (i.e. training, welfare checks)
- There was a suggestion that accompanied 'offshore' missions seem to encourage higher levels of wellbeing and mental health in individuals. If they are not accompanied, scheduled 'welfare visits' from appropriately trained staff should be introduced. It was felt

that it was not reasonable to rely entirely on those who provide more general service delivery as they are not trained for this role.

- It was noted that access to Psychological Support Services (in Canberra) is difficult: need for accessible front of office which offers initial triage by a trained AFP health professional.
- There was a preference for allocations to each operational area, so that people get to know their psychological support person.
- Staff reported that shift workers and/or those whose rosters are flexible and promulgated with short notice, find it difficult to identify a suitable time to seek assistance – described as both a practical barrier to help seeking and also a demonstration of lack of organisational support.
- Support for EAP program (Davidson & Trahaire CorpPsych) was low across the organisation. Members reported that EAP service was difficult to access, there were long wait times for appointments, poorly qualified counsellors (members often told “this is too complex for me”), different person each time (so members often had to repeat their story), a ‘quota’ on amount of services which can be accessed.
- It was reported that many people just go to GP and get Mental Health Care Plan because AFP services are so hard to access and poor quality.
- There was concern expressed by managers that they are unable to refer someone to an independent medical officer with the power and authority to ensure that they attend. Managers did not want to have any feedback from the professional, just wanted to be able to ensure individuals are assessed by a professional.
- There was general support for the newly appointed welfare officers, despite widespread cynicism that this was another knee-jerk reaction to the recent suicide [in Melbourne]. Concerns were expressed about a lack of clarity (e.g., in role, location, support, training), about whether there would be sufficient referral options for welfare officers, and whether the new welfare positions would be back filled, which will create even more demand on existing teams
- Suggestion that need to put a welfare officer (back) into the recruit college – currently lots of welfare issues are being carried by trainers.
- General support for a peer support model to compliment the welfare officers and professional support (i.e. peer support network to sit under the welfare officer network).
- Mixed views about Confidante Network and Safe Place, particularly around trust and confidentiality.
- Strong recommendation for access to good local providers when required. Suggestions for a list of clinical psychologists who can see AFP members for extended sessions (i.e., greater than six).
- Expressed need for greater integration across various welfare and related services; this would be facilitated by increased use of case managers to coordinate interventions across areas
- Staff would like more support for fitness activities, including more fitness sessions conducted by dedicated fitness advisors, including in the regions. some staff are given

time during work hours to go to the gym, but this was not consistent across the organisation.

- Comment on lack of proactive, early intervention approaches. For example, following critical incidents not all areas receive follow-up by senior management or Psychological Support Services. However, on the other hand, others stated AFP was too focused on and too reactive to critical incidents, and less concerned with mental health issues which developed throughout the course of a career.

Theme 9: Attitudes towards mental health reflect stigma

- Noted that it is still very hard for people to acknowledge mental health issues. Members have concerns about confidentiality and trust, bullying, fear of career implications, and fear of losing firearms or composite.

- For those who have actively sought assistance outside the AFP system, some will not disclose and/or are not effectively participating in treatment due to concerns about impact on career (i.e. not filling prescriptions from psychiatrists). Fearful of the implications if they are later 'discovered' as having concealed this information from AFP.

- Comments that senior staff and management are not role modelling help seeking behaviour nor proactively checking on the health and wellbeing of staff members.

- Cynicism about recent efforts from leadership to promote help seeking. Commander Grant Edwards' disclosure of PTSD was seen by some members as being a 'PR exercise' and a response to public criticism. Commander Edwards' experience as a senior executive was seen as not comparable with that of the average AFP employee.

- "Older males" report feeling criticised and alienated in the cultural change process. While recognising that some aspects of the culture need to change, they want to see recognition of the value of good policing practices and for the AFP not to throw away all of the old way of doing things.

- Concerns raised by male members (especially younger ones) that all promotions will go to females, which will impact on their ability to progress in their careers.

- Perceptions among IDG personnel that they are not valued by AFP, role seen as easy and overpaid, no career path, often put in poor (PSO) position on return to Australia.

- Staff felt that there are additional difficulties regarding stigma for LGBTI members in 'male dominated culture'. LGBTI members feel that it is not safe to come out at work, which is a source of stress that is not seen to be taken seriously by the organisation.

Theme 10: Recovery after occupational injury is difficult

- Feedback that stigma, and feared consequences (removing accoutrements even when not necessary) are still working powerfully against individuals acknowledging and seeking support for any mental health issues from within the organisation.

- Repeated concerns about how mental health cases are poorly managed: perceived lack of support, highly stressful and adversarial claims processes; concerns about confidentiality following disclosure; processes to seek help are convoluted and unclear. When members see this happening to a colleague, it reinforces that they should not come forward with mental health issues.

- Perception that the AFP is 'offloading' the problem onto Comcare.

- View that there is insufficient support for teams when they are supporting one or more staff on a return-to-work program. Comments from managers that there is no training for staff or team leaders on how to manage 'difficult' employees and the impact on team productivity.
- Staff report no "triage" or assessment process for return-to-work: when the person is ready to return, they are often just left with nothing to do (consistent with being seen to be a "broken biscuit"). Lack of formal meeting with care team and supervisor to help successful re-integration.
- Feedback that graded return-to-work plans are often hard to organise and badly managed; people often given menial and meaningless tasks, which can be experienced as humiliating and demoralising.
- Concern expressed that the effects of the compensation process can be iatrogenic: long delays in determining claims, making people use sick or other forms of leave while waiting decisions can exacerbate mental health problems.
- Perception that some members are 'playing the system' to get compensation or avoid consequences of performance management or force changes in undesirable posting localities.
- Issues raised also in relation to insufficient management of return-to-work following significant health issues and maternity leave
- Noted complexity in accessing support and compensation when member is a 'lateral' recruit and the psychological injury relates to previous service in another police jurisdiction.

Theme 11: Mental health training at all levels

- Strong support for better training in psychological health and wellbeing. Member express interest in the following areas of training:
    - Mental health literacy
    - Recognition of mental health problems (self and others), self-care, resilience
    - How to help others
    - Effective methods for dealing with negative thoughts
    - Resilience training
- Felt that training for supervisors and managers should be priority (and required for promotion to supervisory/management positions), but necessary at all levels of the organisation.
- Staff cautioned against acting too quickly on training – better to get it right, it is fine to not to train whole teams at a time – take 1-2 members from each team.
- Members do not want a 'train the trainer' model with internal, unqualified trainers: needs to have credibility, trainers who are experts in mental health.
- Members do not want online-only ("i-aspire") training or sending out leaflets; very keen for practical, interactive training from mental health experts.

- Expressed desire to create a stronger “training culture” by building in rewards, links to PDA processes, and a genuine discussion about individual training needs. This relates not only to mental health training, but training more generally.
- Recognition that single training in mental health is not enough: principles must be constantly reinforced and operationalised in every aspect of work.
- Suggestions for enhanced training of mental health issues in recruit training.

Theme 12: Meaningful psychological assessment

- Concern that psychological assessments are just a bureaucratic hurdle and not about caring for the wellbeing of staff. Psychological assessments were not reliably provided to many members following deployments or after critical incidents.
- Expressed need for some kind of meaningful face-to-face component (e.g., as part of regular visits by the same psychologists to operational, regional and remote locations)
- Repeated assertions that regularity and quality of assessments in high-risk areas is constantly reducing, including in overseas deployments where reported exposure to potentially traumatic experiences is elevated.
- Suggestions for change:
    - Potential for regular low key psychological assessments for all, even if it’s only some kind of ‘self-check’). Recommendation for regular “baseline” fitness assessment (PCA – physical capability assessment) for all members, which would give the opportunity for some other self-care advice and possibly a simple mental health screen.
    - Option for online ‘mental wellbeing check’
    - Introduction of a mandatory mental health screen for all members semi-regularly (i.e., every 3-5 years).
- Comment that at recruitment, only sworn staff undergo psychological selection processes.
- Concerns were raised that Psychological Support Services are not represented on selection panels or strategically involved in designing recruitment policies and processes.

Theme 13: Professional standards complaints processes

- Perceptions that it is very easy for someone to make a complaint (e.g., of bullying or unfair promotions), very hard for the person accused to clear their name.
- Often told that someone has made a complaint but not what it is; repeated stories of members having to wait for long periods of time to find out the nature of the complaint. There was some concern that if a PRS member handling the case was on leave, the accused member has to wait until they return before anything further happens.
- Difficult for members not being allowed to talk to anyone about complaints so options for support are seriously limited. Members reported that this has serious implications when one partner of a married couple (both in AFP) is involved.

- Concern that PRS staff are poorly trained and poorly supported in their role; poor handling of confidentiality.
- Suggestions for change:
    - Shorten the process by improving efficiency, placing pressure on the multiple layers who review the reports to do so quickly.
    - Allow minor offences to be dealt with quickly. Allow the member to admit to the misdemeanour, small note on file, etc, without going through the whole process.
    - Confidential psychological support must be offered to all under investigation, and must be from an outside provider because of trust issues and reporting requirements for internal providers.

Theme 14: Lack of clear policies, procedures and guidelines

Members made the following comments about areas for improvement in policies, procedures and guidelines

- Clear and specific instructions about psychological support for specific areas, especially high-risk groups are lacking: i.e., policy regarding how members should be selected and prepared for the role, how often should they be assessed for psychological wellbeing, when/what exit interviews should be provided. Currently processes in high-risk areas seems to be largely discretional and subject to available resources.
- Clear and transparent instructions about promotion process: criteria, application process, interviews process, and outcomes. Currently a strong perception that procedures are routinely circumvented and it depends on “who you know”.
- Lack of clear career pathways, management of promotions are not clear.
- Clearer guidelines on how to manage reports of bullying. Currently multiple different guidelines that need to be considered; the process is complex to understand and difficult to navigate.
- Clearer guidelines on how to manage poor performance; better training and support for managers will help, but so would clear, step-by-step guidelines.
- Clear guidelines (as far as possible) on when to remove accoutrements (particularly weapons), and using those guidelines to drive appropriate training and support services for managers in making those decisions.

There were highly variable expectations regarding what the AFP is responsible to provide in relation to wellbeing (i.e., paid time to access gym, unrestricted access to mental health treatment) and an apparent lack of clarity about what can reasonably be expected.

Theme 15: Learning from others

- Members noted that given the strategic and operational practices of partnering with other agencies, there may be benefit in learning from the state forces about mental health practices.
- Members indicated positive perceptions of programs in a number of state policing agencies. Many felt that the state police forces had far more sophisticated and effective policies around mental health than the AFP.

- Strong feeling that ADF does leadership training very well. Members would like to see the AFP learn from these kinds of organisations.
- Comments that there needs to be a culture of learning from mistakes: current culture just "punishes" members for mistakes with no attempt to address the underlying causes or to learn from mistakes to improve future outcomes.

Family teleconferences

- Unlike focus groups with employees of AFP, family members highlighted the impacts of cumulative exposure to PTEs more consistently than members themselves. Family members suggested that AFP members may be less willing to discuss the impacts of PTEs due to a culture where it is difficult to acknowledge being affected by traumatic events, and/or members lack self-awareness to identify impacts, which are more readily observable to family members.
- Impacts of child exploitation were highlighted as particularly difficult for members with children.
- Family members reported that they were generally were not provided supports or information prior to or during overseas postings. There were several stories where family members were not given direct contact numbers from the AFP to allow them to check their family members were safe following covert missions.
- In general, family members were not aware of mental health support services available for members. Family members who reported acting as a caregiver for an AFP member with a mental health problem indicated that it was difficult to advocate for their family member to get support from within the AFP. Views of rehabilitation services within the organisation were typically negative, and perceptions/experiences of ComCare processes were described as adversarial. There was the perception that wellbeing services within the AFP were on the side of the ComCare/AFP, not the member. In the case of a family member who was also a police officer, stated they would be reluctant to suggest seeking assistance from AFP as this would be both anxiety provoking and would not be in the best interest of the family.
- Partners of AFP members (mostly females) reported difficulties managing family responsibilities and their own careers due to the long/unpredictable hours worked by members. They described difficulties for members in switching off after work, "they're there [home], but not there".
- Concerns were raised about the physical safety and mental health of serving family members.
- Attitudes toward mobility were mixed. Some saw it as a positive for partners and families (i.e., life enriching experience of living overseas). For families where both partners were AFP members, some reported that the AFP was good at helping manage this to allow families to stay together. Others mentioned that posting changes occurred without consultation even though they could have a negative impact on one's career and/or the overall financial situation of the family. There were also reports that some members were not supported to live near children (particularly where parents were separated), despite repeated requests to the AFP for transfer to locations where children were living.
- Suggestions made by family members:

- Regarding overseas deployments: better supports offered regarding information about who to contact when member is deployed; AFP to support family networks of deployed members (i.e., family members volunteer to be connected with other members' families on similar missions); better follow up screening for mental health post deployment, as well as supports/information regarding re-integration of family member back into family life; better practical supports (i.e., child care policies and supports).
- Formal processes to help families become more aware of support services available to members; formal seminars for family members in supporting members' wellbeing and recognising mental health changes in their partner.
- Active support by AFP for setting up of informal support groups for family members i.e. regular social events.
- In general, consensus that regular mental health/wellbeing checks should be routine for members.
- Greater consultation and consideration of the impact of the job, including changes in role and location, on the family.

Written submissions

Staff and their families were invited to make written submissions either in addition to or instead of attending an interview or focus group. These were emailed to the Phoenix Australia project team and all information was treated as anonymous. They were invited to, but not required to, use the focus group questions as a guide for their submission.

Overall, there were 36 written submissions: 32 from AFP staff members (four of these noted their experience working for other organisations, including other police jurisdictions and the military), and four were family members.

The key themes and concerns raised were consistent with those raised in the interviews and focus groups. Over half of the responders drew on their own mental health and/or health experiences, or the experiences of their family member, to comment on issues with current AFP support services, and concerns relating to compensation and return to work processes. Many mentioned exposure to multiple traumas, primarily work related.

The majority of submissions also raised issues regarding managerial decisions and the negative impact on the health and wellbeing of individuals and their families. Issues ranged from recruitment processes, posting and promotions, geographical transfers and management of work tasks. Most submissions included suggestions on ways to improve AFP culture, management processes and support services for the benefit of the health and wellbeing of the workforce. A small number raised specific issues they had failed to receive resolution from through other official channels. One submission highlighted their positive experiences of support from the AFP following significant mental health and health incidents.

Appendix 8: Staff survey: Method and results

Aim

The aim of the online survey was to gain a better understanding of the psychological health and wellbeing of AFP staff, as well as the stressors they experience, and perceptions about AFP mental health services. The survey also created an opportunity for all AFP staff to contribute to the mental health review.

Method

Wherever possible, validated measures with relevant normative data were selected. Detailed information about each measure is presented below. The survey was approved by the Human Ethics Committee at the Melbourne University (ID: 1749543).

The survey was delivered online via SurveyMonkey and was open between 27th June and 31st August. The survey was intended to take approximately 20 minutes to complete and internal piloting indicted that this was the case.

Measures

Respondents were asked to provide **demographic information** described in Table 1.

Table 1. Demographic information provided by survey respondents

Variable	Subcategories
Age	18 – 24, 25 – 34, 35 – 44, 45 – 54, 55 – 64, 65 – 74, 75 or older
Gender	Male, female, indeterminate/Intersex/unspecified, prefer not to say
Marital status	Single (never married), married, de facto, separated /divorced, widowed
Length of service (years)	<1, 1-2, 3-5, 6-10, 11-19, 20-29, 30+
Role	sworn, professional/unsworn, protective service officer; contractor, other
Work location	ACT, NSW, NT, QLD, TAS, VIC, WA, international missions, international posts or external territories
Business area	ACT Policing, Crime Operations, Counter Terrorism, International Operation, Org. Crime and Cyber, People, Safety and Security, Protection Operations, Specialist Operations, Support Capability, Technology and Innovation, Workforce Development, Chief of Staff, Reform, Culture and Standards, Chief Financial Officer, Legal
	Other
Work hours	Shift work or roster, regular hours (Monday- Friday), on call, flexible workplace arrangement

Operational stressors were measured using the Operational Police Stress Questionnaire (PSQ), which is a measure that rates the level of perceived stress for 20 commonly reported

operational events encountered by police (McCreary & Thompson, 2006). Each item is scored on a scale of 1 (*no stress at all*) to 7 (*a lot of stress*). High scores on the scale indicate higher levels of perceived stress. Respondents could also select '*not applicable'* for each operational stressor.

Organisational stressors were measured using the Organisational Police Stress Questionnaire (PSQ), which is a measure that rates the level of perceived stress for 20 commonly reported organisational experiences encountered by police (McCreary & Thompson, 2006). Each item is scored on a scale of 1 (*no stress at all*) to 7 (*a lot of stress*). High scores on the scale indicate higher levels of perceived stress. Respondents could also select '*not applicable'* for each organisational stressor.

Exposure to critical incidents was assessed using the Critical Incident Checklist, a 20 item checklist that identifies the frequency of exposure to a range of critical incidents. This Checklist was based on the Police Life Events Schedule (Carlier & Gersons, 1992), and adapted for the purpose of this survey.

Bullying was measured using the bullying item from the Australian Workplace Barometer project, which assesses the duration and frequency of personal exposure to bullying (Dollard et al., 2012).

Leadership commitment to psychosocial safety and wellbeing was assessed using the Psychosocial Safety Climate Survey (PSC-12), a 12 item measure that assesses individuals' perceptions of the workplace policies, practices and procedures for the protection of worker psychological health and safety (Hall et al., 2010). The measure has four components:

16. perception of senior management support and commitment (e.g., quick and decisive action by managers to address problems that affect psychological health)

17. perception of management priority (e.g., relative priority given to safety versus productivity)

18. perception of organisational communication (e.g., processes for two-way communication with employers to resolve and prevent work stress)

19. perceptions of organisational participation and involvement (e.g., consultation on psychological health and safety issues with staff through all levels of the organisation).

Senior leadership was defined as the senior executive group (SES) at AFP.

Respondents were asked to rate items across all factors on a scale of 1 (*strongly disagree*) to 5 (*strongly agree*), such that higher scores indicate more positive views of the organisational commitment to psychosocial safety. Scores on the PSC have been found to be related to risk of job strain (high demands and low control) and poor mental health outcomes. The following cut-offs have been established for the PSC: scores of 41 or above

represent low risk; scores between 37 and 40 represent moderate risk; and scores below 37 represent high risk (Bailey, Dollard, & Richards, 2015).

Burnout was measured using a single item measure previously used in policing populations (Jakubauskas & Wright, 2012). This item identifies the degree to which someone believes they are experiencing burnout from their work and is measured on a scale of 1 (*strongly disagree*) to 5 (*strongly agree*), such that higher scores indicate higher levels of perceived burnout.

Current wellbeing was assessed using items from the World Health Organisation Quality of Life assessment (WHQQOL-BREF, The WHOQOL Group, 1998), which asked staff to rate firstly their satisfaction with their physical and mental health in the past four weeks on a scale of 1 (*very dissatisfied*) to 5 (*very satisfied*), and, secondly, their quality of life on a scale of 1 (*very poor*) to 5 (*very good*). Higher scores on both items were associated with higher levels of wellbeing and quality of life.

Mental health indicators were measured using the following:

- Kessler Psychological Distress Scale (K10), a 10 item measure of psychological distress (Kessler et al., 2002). The scale asks about non-specific psychological distress, and concerns the level of anxiety and depressive symptoms a person may have experienced over the past four weeks. Cut off scores have been established for individuals who are likely to: be well (10 – 19); have a mild mental health disorder (20 – 24); have a moderate mental disorder (25 – 29); and have a severe mental disorder (30 – 50) (Australian Bureau of Statistics, 2012). Scores below 25 indicate either no mental health problems or a mild mental health disorder, whereas scores above 25 indicate the likely presence of a moderate to severe mental health disorder. In this report, low distress refers to K10 scores below 25, whereas high distress refers to scores above 25.

- Patient health questionnaire (PHQ-9), a 9 item measure of depression symptoms (A. Martin, Rief, Klaiberg, & Braehler, 2006), which also includes an additional non-scored item which assigns weight to the degree to which depressive symptoms have affected the person's level of functioning. Cut off scores for depression diagnoses were established using no depression (<2 symptoms), likely subthreshold depression (2 – 4 symptoms) and likely major depression (5 – 9 symptoms) (Kroenke, Spitzer, & Williams, 2001).

- General anxiety disorder assessment (GAD-7), a 7 item measure of anxiety symptoms (Löwe et al., 2008), which also includes an additional non-scored item which assigns weight to the degree to which anxiety symptoms have affected the person's level of functioning. Cut off scores have been established for low (0 – 4), mild (5 – 9), moderate (10 – 14) and severe (15+) anxiety (Spitzer, Kroenke, Williams, & Löwe, 2006).

- Posttraumatic stress disorder checklist for DSM-5 (PCL-5), a 20 item measure of posttraumatic stress disorder symptoms (Blevins, Weathers, Davis, Witte, & Domino, 2015). A cut-off of 33 is considered a positive screen for PTSD.
- Alcohol use disorders identification test (AUDIT-C), a three item measure of problematic alcohol use (Bradley et al., 2007). A cut off score off score of 8 is considered to indicate severe risk of alcohol related problems.

On all of these mental health measures, higher scores indicate higher levels of distress or more mental health problems or symptoms. In our analysis, we have also used validated clinical threshold scores associated with the *likely* presence of a mental health disorder. However, the presence of a mental health disorder can only be confirmed through further clinical assessment and therefore these results should be interpreted accordingly.

Access to and perceptions of mental health support services was assessed by asking about attitudes and experiences of seeking support. Firstly, respondents identified how likely it would be for them to seek support from a range of sources (both internal and external, professional and non-professional supports) if they were concerned about work stress or wellbeing. Each support type was rated on a scale of 1 (*very unlikely*) to 5 (*very likely*), such that higher scores indicate greater likelihood that the member would engage with support from a particular source.

Additionally, respondents were asked to identify whether they had accessed any of the following services: AFP psychology services, employee assistance program (Davidson Trahaire),chaplains, Confidante Network, Safe Place, ACT Welfare Officers, and external providers (psychologists, psychiatrist, GP) in the past year. If they endorsed accessing a service in the past year, they were then asked if they had found the service (a) useful and (b) easy to access. Both items were scored as 1 (*not at all*) and 5 (*extremely*), such that higher scores were associated with more positive views of this support service.

Barriers to seeking support was assessed by asking staff to rate their level of concern in seeking assistance for mental health problems in relation to ten commonly reported barriers among similar populations relating to stigma, beliefs that help would not be effective, confidentiality, and fears regarding future career opportunities (Forbes et al., 2017, In Press). Each barrier was scored on a scale of 1 (*not at all a concern*) and 5 (*definitely a concern*), such that higher scores are associated with perceptions of increased barriers to seeking support.

Career satisfaction and organisational commitment was assessed by asking respondents to report their (a) overall job satisfaction and (b) commitment to the AFP as an organisation on a scale of 1 (not at all) and 5 (extremely), such that higher scores indicate greater satisfaction and commitment. Finally, they were asked to estimate how they long they plan to remain with the AFP.

Results

The results of the survey are presented below in the following order:

- Response rates, broken down by job type, age, gender, marital status, length of service, role, location and business area. Due to low numbers reporting indeterminate, intersex or unspecified (n = 12), gender was re-categorised into three groups: those who identified as male or female and a third group ('Other') comprising of those who identified as indeterminate, intersex or unspecified and those who preferred not to say.
- Demographics of respondents: Age, gender, marital status, length of service,
- Employment information: Job type, primary work location, business area, employment conditions (shift work, regular hours, flexible work arrangements etc)
- Operational and organisational stressors and critical incidents by job type (sworn, unsworn, PSO, contractor)
- Bullying by job type, gender, length of service. location (where cell size permits) and business area (where cell size permits)
- Burnout by job type, gender, length of service and location (where cell size permits) and business area (where cell size permits)
- Psychosocial safety climate – proportion in low, medium and high risk categories against worker norms
- Wellbeing measures (QoL, health satisfaction, PHQ-9, GAD-7, PCL, AUDIT-C and K10) – average scores across AFP and by job type
- Because correlations are high between PHQ-9, GAD-7, PCL and K10. we will use K10 as a proxy measure of mental health and look at mental health by age, gender, length of service, location and business area, as well as the association between current mental health and bullying, burnout and psychosocial safety climate score
- Seeking support by job type and for those with K10 scores indicating high levels of distress
- Barriers to help seeking by job type and for those with K10 scores indicating high levels of distress
- Help received in the past year for each service by job type, gender, age, location (where cell size permits) and business area (where cell size permits) and for those with K10 scores indicating high levels of distress
- Job satisfaction, commitment to AFP and how long will remain in the job by job type, gender, age, location (where cell size permits) and business area (where cell size permits), gender and age

Response rate

The AFP counts its staff in two different ways. The first of these, known as the ‘Head count’ is inclusive of sworn members, unsworn/professional staff and protective service officers, and totals 6510. The second of these, the ‘Resource count’, is inclusive of the aforementioned staff groups as well as contractors, and totals 7051. Given the very low response rate among contractors, we have used the head count figure of 6510 rather than resource count of 7051 to determine response rates for the survey (see

A total of 2953 individuals completed more than one answer, which represents a response rate of 45%. When considering only those who completed the survey, the response rate was 33%. Response rates for those who completed at least one item have been broken down by age, gender, marital status, length of service, role, location and business area and are presented in Appendix 0-1. It is important to note that all available data was analysed where it was appropriate to do so (i.e., incomplete responses were not dropped from the analysis where it was possible to include them), and thus the number of responses for each question are not always consistent with the total number of overall responses.

To summarise, response rates tended to be higher among staff 35 years of age and older (44-54%) compared to those younger than 35 years of age (32-38%), females had higher response rates than males (68% and 30% respectively), response rates among professional (50%) and sworn (44%) staff were higher than protective service officers (25%), and the lowest response rates across the AFP were observed among staff serving internationally (22%). Overall, these response rates indicate that there was good representation of staff across the AFP such that the results, when considered alongside evidence from the focus groups, are likely to provide valid and valuable information to inform this review.

While the response rates indicated good participation across the organisation, it is important to recognise that participation was voluntary and it was not possible to control for self-selection biases beyond examining how representative the sample was relative to the demographics of the whole staff. This is presented in Table 2.

Table 2. Number of respondents, head count and resource count by job type

	Number of respondents	Head count	Resource count
Sworn	1487	3369	3370
Unsworn/Professional	1227	2460	2460
PSO	173	681	681
Contractors	24	0	540
Other[1]	13	0	-
Did not specify(i.e., missing)	29	-	-
Total	2953	6510	7051

PSO = Protective Service Officer
[1] 'Other' consists of consultants, external, secondment non pay, special members and volunteers

Demographics and employment characteristics among respondents

The most commonly endorsed age was 35 to 44 years (35%), followed closely by 45 to 54 years (34%), 19% of respondents were aged 25 to 34, 11% aged 55 to 64, 1% aged 18 to 24 and 1% aged 65 years or older. Around half (54%) of the survey respondents were male, 42% were female, and 4% were either indeterminate/intersex/unspecified or preferring not to say. This gender composition is reasonably representative of the AFP population (64% male).

In terms of marital status, 58% reported being married, 16% were single (never married), 15% were in a de facto relationship and 11% were separated or divorced. In terms of working conditions, 63% of people reported that they have regular work hours (i.e. Monday to Friday), 32% have shift work or are rostered on, 22% are on call, and 19% have flexible workplace arrangements.

The most common length of service at the AFP was 11-19 years (39%), followed by 6-10 years (26%), 3-5 years (12%), 20-29 years (11%), 30 plus years (6%), 1-2 years (4%) and less than a year (2%).The greatest number of respondents were sworn members (51%), followed by Professional/unsworn staff (42%), Protective Service Officers (6%) and contractors (<1%).

The majority of responses (57%) came from employees based in the Australian Capital Territory (ACT), with 15% of responses coming from New South Wales (NSW), 11% from Victoria, 7% Queensland, 5% Western Australia, 2% South Australia, <1% Northern Territory

and <1% from overseas postings (international missions, international posts and external territories combined). One response was received from Tasmania.

The number of people who responded and response rates by a range of demographics is presented in *Appendix 0-1*.

Sources of stress

Operational stressors

Averaged across the entire organisation 'finding time to stay in good physical condition' (*M*=3.9, *SD*=2.0), 'paperwork' (*M*=3.8, *SD* = 2.0), and 'fatigue' (*M*=3.7, *SD*=2.1) were rated as the three most stressful operational activities, falling in the 'moderately stressful' range (see Figure 1). 'Working alone at night' (*M*=2.2, *SD*=1.7), 'negative comments from the public' (*M*=2.3, *SD*=1.7) and 'friends/family feeling the effects of the stigma associated with the job' (*M*=2.4, *SD*=1.9) were rated as the three least stressful operational activities, falling into the 'low to moderately stressful' range. Ratings of operational stressors broken down by role are shown in Figure 1 and *Appendix 0-2*.

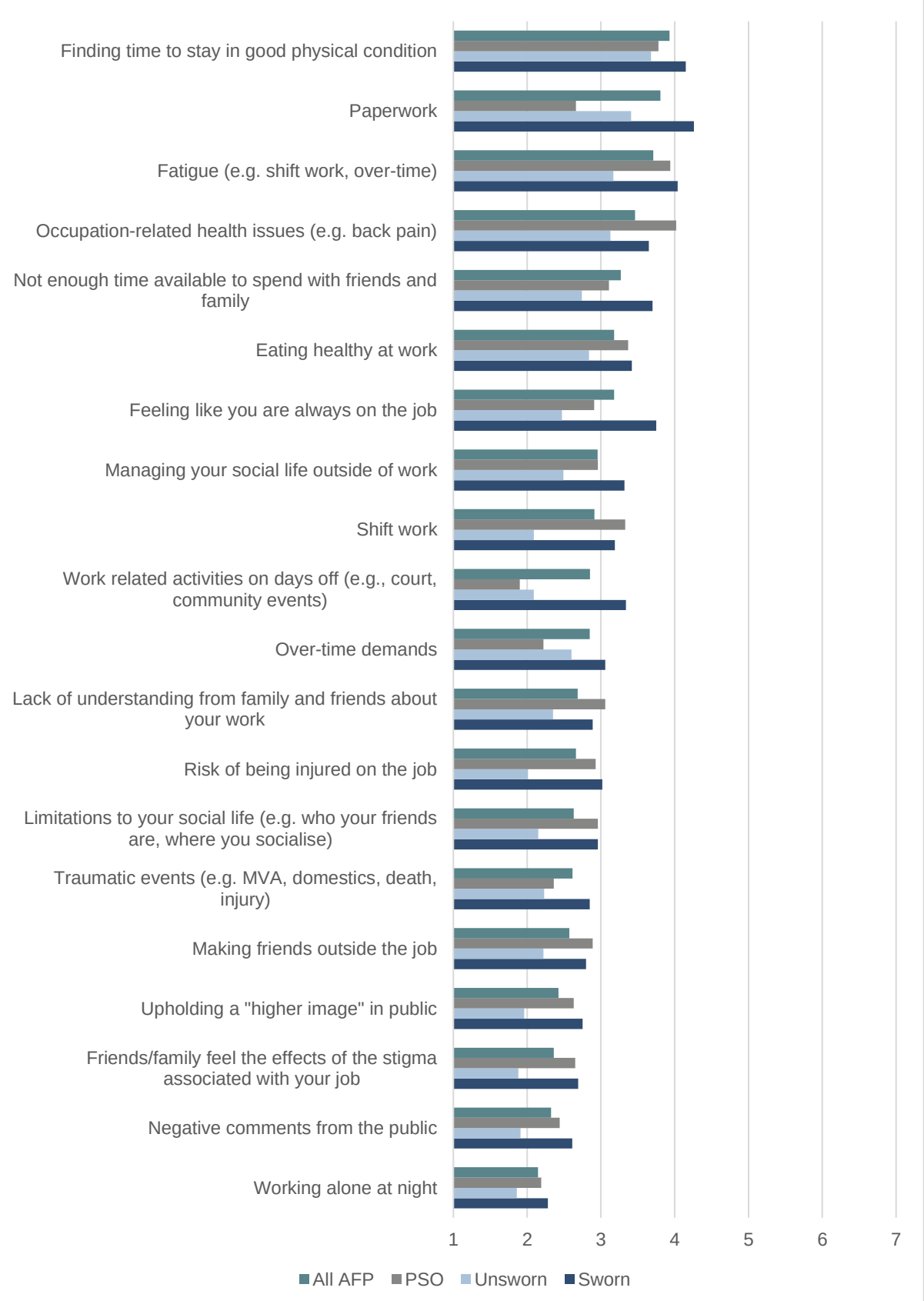


Figure 1. Mean scores for AFP respondents by role on sources of operational stress (high scores equate to higher stress ratings).

Organisational stressors

Averaged across the entire organisation ‘staff shortages’ (*M*=4.9, *SD*=2.0), ‘the feeling that different rules apply to different people (e.g. favouritism)’ (*M*=4.8, *SD*=2.0) and ‘bureaucratic red tape’ (*M*=4.6, *SD*=2.0) were rated as the top three organisational stressors, falling into the ‘moderately stressful’ range. ‘Internal investigations’ (*M*=2.4, *SD*=2.0), ‘dealing with court system’ (*M*=2.5, *SD*=1.8) and ‘if you are sick or injured your co-workers seem to look down on you’ (*M*=2.7, *SD*=2.0) were rated as the three least stressful sources of organisational stress, falling into the ‘low’ stress range. Ratings of organisational stressors for the entire AFP and broken down by role are shown in Figure 2 and *Appendix 0-2*.

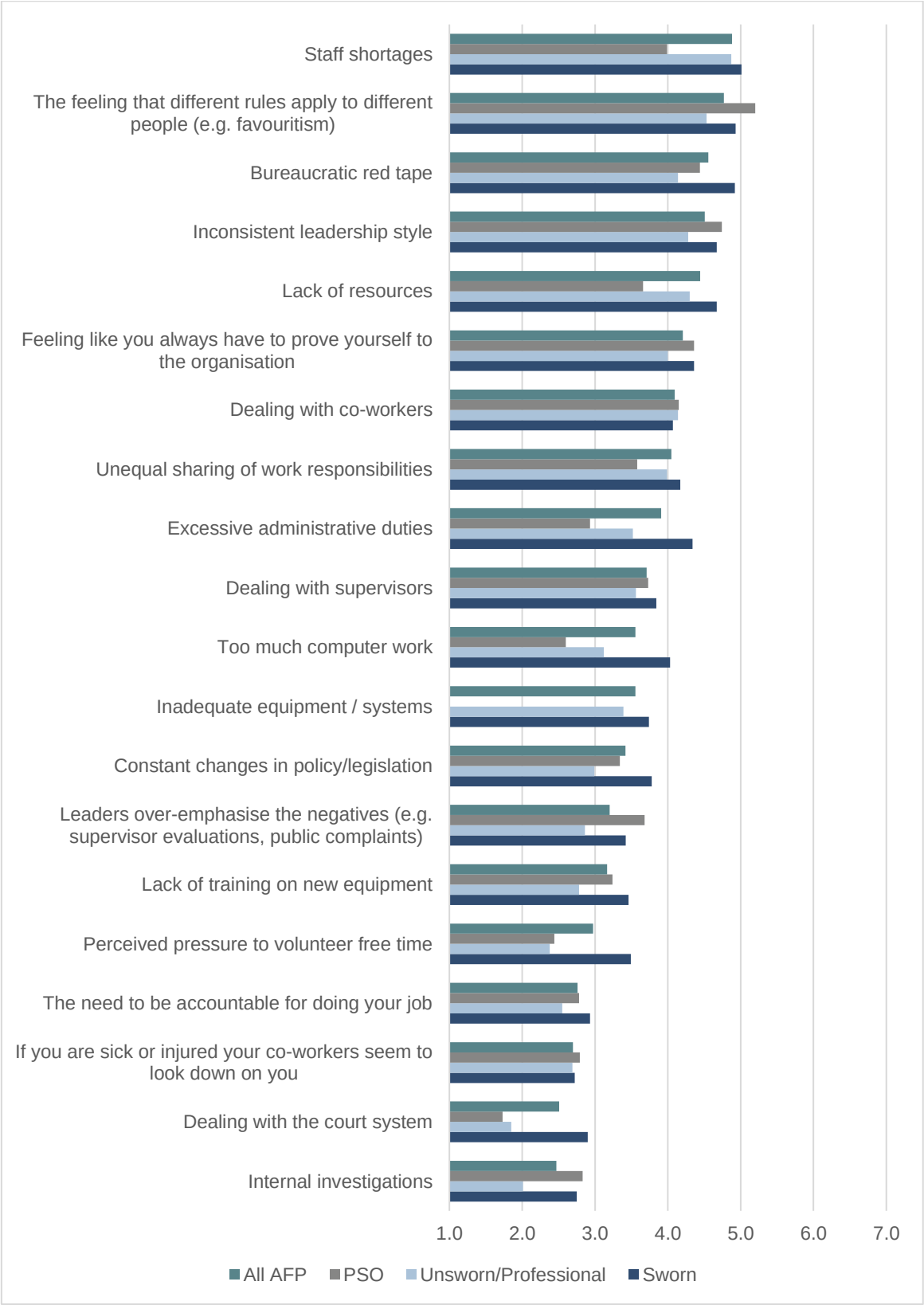


Figure 2. Mean scores for AFP respondents by role on sources of organisational stress (high scores equate to higher stress ratings).

Critical incidents

Table 3 describes the proportion of AFP respondents by role, who have ever experienced any of the critical incidents listed in the critical incident checklist.

When examined by role, 57% (n = 80) of PSO, 56% (n = 548) of unsworn/professional, and 24% (n = 300) sworn members had never experienced any of the critical incidents listed in the checklist. Findings indicate that in general, sworn members are more likely to have experienced a range of critical incident types than either unsworn/professional staff or PSOs. The frequency of exposure to each critical incident by role is depicted in *Appendix 0-3*.

We also calculated the total number of critical incidents (from the checklist of 20 items) that had ever been experienced in their lifetime for individuals and examined whether this varied by role and business area. On average, sworn members (M=4.6, SD=5.7) had experienced more critical incidents than both unsworn/professional (M = 2.1, SD = 4.0) and PSOs (M =2.2, SD = 6.4), $F(2, 2379) = 68.78$ $p<.001$. The average number of critical incidents by business area is depicted in Figure 3.

It is important to note that given the high level of mobility in the organisation we cannot conclude from this analysis that working in a particular business area is associated with greater exposure. Rather this information highlights, for example, that staff currently working in ACT Policing have the highest number of exposures to potentially traumatic events in their lifetime, but more detailed information is required to establish in what setting these exposures occurred.

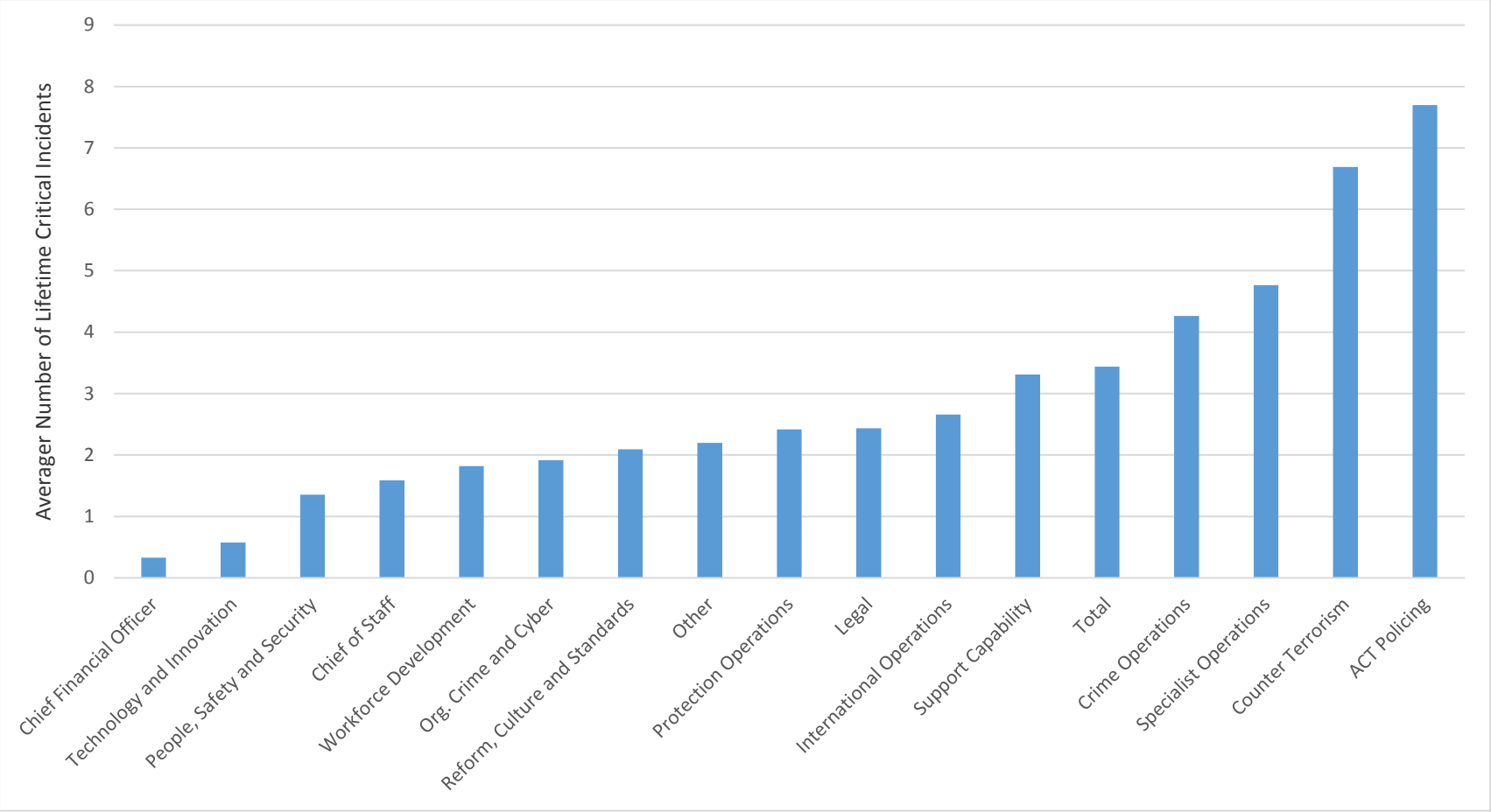


Figure 3. Average number of exposures to critical incidents (lifetime history) by business area. Note: This chart does not depict the number of critical incidents experienced whilst working in each business area.

Table 3. Count and proportion of AFP respondents who have ever experienced the following critical incidents by role

	All AFP		Sworn		Unsworn		PSO	
Critical incident type	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Major or significant incident where police response is complex or protracted	685	28%	539	43%	120	12%	17	12%
Viewed objectionable material, such as child exploitation material or terrorism-related images	504	21%	309	25%	171	17%	17	12%
Responded or were involved in a terrorism-related event	489	20%	324	26%	139	14%	20	14%
High profile event leading to internal investigation and/or critical media attention	457	19%	311	25%	125	13%	13	9%
Responded or were involved with a case that had a fatality (including suicide and multiple fatalities)	395	16%	284	23%	98	10%	9	6%
Death of an AFP member from suicide	363	15%	215	17%	125	13%	16	11%
Serious threat, assault, sexual assault or injury to another AFP staff member, including exposure to toxin/bodily fluid	357	15%	295	24%	48	5%	11	8%
Other work related event that results in a traumatic stress reaction for you (Please specify below)	346	14%	214	17%	116	12%	12	9%
Exposure to a horrific injury or accident scene	345	14%	267	21%	63	6%	13	9%

Responded or were involved in a case that concerned extreme acts of cruelty, such as human trafficking, torture, or brutal violence	307	13%	210	17%	85	9%	8	6%
Serious threat, assault, sexual assault or injury to yourself, including exposure to toxin/bodily fluid	287	12%	239	19%	33	3%	12	9%
Child sexual abuse	282	12%	190	15%	83	8%	6	4%
Serious case of child abuse/neglect	272	11%	197	16%	67	7%	7	5%
Administered emergency first aid (e.g. resuscitation)	181	8%	144	12%	20	2%	16	11%
Attended a major or significant incident where victims were known to you, or you identified with victim	119	5%	98	8%	13	1%	6	4%
Serious case of animal cruelty*	111	5%	65	5%	43	4%	N<5	-
Death or injury of a community member resulting from police action*	67	3%	48	4%	14	1%	N<5	-
Exposure to a natural disaster, which may or may not have resulted in death*	59	3%	37	3%	15	2%	5	4%
Involvement in riot or crowd control in which people were injured*	58	2%	46	4%	N<5	-	7	5%
Death of an AFP member in the line of duty*	44	2%	26	2%	12	1%	5	4%

* Significant differences between roles not able to be statistically established. Green = lower proportions than expected, Red = higher proportion than expected if no association between role and ever experiencing a particular critical incident (z score =>2).

Bullying

Of the respondents, 23% (n = 672) reported having personally experienced bullying in the workplace in the past six months. In comparison, data collected from a sample of 5,743 Australian employees from 2009 – 2011 indicates that on average, 7% of Australian workers reported bullying according to the same definition (Dollard et al., 2012).

Of the AFP respondents who reported experiencing bullying, 33% (n = 220) were exposed at least once per week, 32% (n = 219) were exposed at least once per month, 19% (n = 128) said they had been exposed but rarely, and 16% (n = 108) were exposed to bullying daily. As to be expected, those who had reported bullying had significantly higher levels of distress as measured by the K10 (M = 24.0, SD = 9.8) than non-bullied staff (M =17.8, SD = 6.7); $t(2371)= 17.3$, $p < 0.0001$.

When bullying was investigated by gender there was a significant difference in the proportion of individuals who reported having experienced bullying ($\chi^2(2) = 9.44$, $p = 0.009$). Those who identified their gender as other (i.e., indeterminate/intersex/unspecified/preferred not to say) 31 out of 80 (39%) reported experiencing bullying, for females 295 of 1065 (28%), and for males 346 out of 1404 (25%). Adjusted residuals were calculated for each of the cells in order to determine which cell differences contributed to the significant chi square results. The results indicated that statistically, a higher proportion of those who identified their gender as 'other' reported experiencing bullying, while a smaller proportion of males reported experiencing bullying.

Reported bullying rates did not vary by age, role, length of service, or location. There was, however, a significant difference in the proportion of individuals who reported bullying by business area ($\chi^2(15) = 55.63$, $p <0.001$). Adjusted residuals were calculated for each of the cells in order to determine which cell differences contribute to the significant chi square results. The results indicate that statistically, a higher proportion of those who work in Protection Operations (36%, n = 126) and Support Capability (35%, n = 93) and a smaller proportion of those in Organised Crime and Cyber (17%, n = 36) reported bullying. Refer to Appendix 0-4 for a full list of the percentage of respondents who reported bullying by each business area.

Burnout

Among respondents, 47% agreed or strongly agreed that they feel burned out from their work, 23% neither agreed nor disagreed, and 30% disagreed or strongly disagreed. Distress levels (as measured by the K10) were significantly higher among respondents who either agreed or strongly agreed that they had experienced burnout ($M=22.9$, SD=8.7) compared to those who neither disagreed or agreed, disagreed or strongly disagreed (M=16.3, SD=5.9), $t(2371)= 21.7$, $p < 0.0001$.

Chi square test showed that burnout was significantly associated with role ($p<.01$), length of service ($p<.01$), location ($p<.01$) and business area ($p <.01$), but not gender. Adjusted

residuals were calculated for each of the cells in order to determine which cell differences contribute to the significant chi square results and results are depicted in Table 4.

As shown in Table 4, the proportion of burnout was higher than expected in those working in ACT policing, those who are sworn members, those with length of service of 6-10 years and those located in ACT.

Table 4. Proportions of burnout by business area, role, length of service and location

% 'Agree' or 'strongly agree' to feeling burned out from their work							
Business area	**%**	**Role**	**%**	**Length of Service**	**%**	**Location**	**%**
ACT Policing	59%	Sworn	43%	<2 years	29%	ACT	42%
Crime Operations	42%	Unsworn	39%	3 to 5	42%	NSW	41%
Counter Terrorism	39%	PSO	27%	6 to 10	44%	NT	26%
International Operations	30%			11 to 19	41%	QLD	36%
Org. Crime and Cyber	37%			20 to 29	34%	SA	22%
People, Safety and Security	38%			30+	34%	VIC & TAS	40%
Protection Operations	32%					WA	34%
Specialist Operations	45%					International	28%
Support Capability	41%						
Technology and Innovation	48%						
Workforce Development	33%						
Chief of Staff	44%						
Reform, Culture and Standards	37%						
Chief Financial Officer	29%						
Legal	45%						
Other	40%						

Green = lower proportions than expected, Red = higher proportion than expected if no association between burnout and (1) business area (2) role (3) length of service) and (4) location (z score =>2).

Psychosocial safety climate

AFP respondents overall reported a mean psychosocial safety climate (PSC-12) score of 31.2 (*SD* = 10.4), which, being less than 37, indicates high risk for employee depression and job strain. Previous research has found that across Australia the psychosocial safety climate of most health and community service industries are in the medium risk range (Dollard et al., 2012). The breakdown of scores within AFP respondents, revealed that 70% (n = 1726) fell into high risk, 12% (n = 284) fell into moderate risk and19% (n = 459) fell into low risk.

Psychosocial safety climate scores differed significantly between staff reporting bullying and staff not reporting bullying. Staff who reported bullying reported significantly lower psychosocial safety climate scores (*M*=25.5, *SD*=9.7), indicating higher risk, than staff who did not report bullying (*M*= 33.2, *SD*=9.9); t(2467)= -17.2, $p < 0.0001$). The presence of bullying was associated with PSC-cut off scores (i.e., membership in low, moderate or high risk groups), $\chi^2(2) = 114.7$, $p < 0.001$. Eighty-six percent (n = 560) of those who reported bullying compared to 64% (n = 1166) of those who did not report bullying were in the high risk category. A greater proportion of survey respondents who reported bullying were in the high risk category for employee depression and job strain, while a greater proportion of survey respondents who did not report bullying were in the medium or low risk categories. This is consistent with previous research indicating that a significant part of psychosocial safety climate is absence or presence of bullying (Dollard et al., 2012).

When investigated by AFP role (sworn, unsworn/professional, PSO), unsworn/professional staff had higher psychosocial safety climate scores (*M*=33.5, *SD*=10.2), indicating relatively lower risk (although still placing them in the high risk category), than both sworn (*M*=29.6, *SD*=10.3) and PSO (*M*=28.9, *SD*=10.4) members, who did not differ from one another, $F(2,2438)=45.1$, $p<0.001$. Further, role was associated with psychosocial safety climate cut-off scores, ($\chi^2(4) = 68.3$, $p < 0.001$), and adjusted residuals were calculated for each of the cells in order to determine which cell differences contribute to the significant chi square results. There was a higher proportion of both PSO (79%) and sworn (76%) members in the high risk category, and a lower proportion of unsworn/professional members (61%) in the high risk category. Refer to Appendix 0-5 for the percentage of respondents in each psychosocial safety climate cut-off category by role and business area.

Psychosocial safety climate risk level was associated with psychological distress, as measured by the K10 ($F(2,2370) = 75.93$, $p<.001$). Individuals in the high risk category (*M*=20.7, *SD*=8.1) had significantly higher levels of distress than both individuals in the moderate (*M*=17.1, *SD*=6.0), and low risk (*M*=16.0, *SD*=5.6) categories, see Figure 4. Distress levels were not significantly different for individuals in the low and moderate categories.

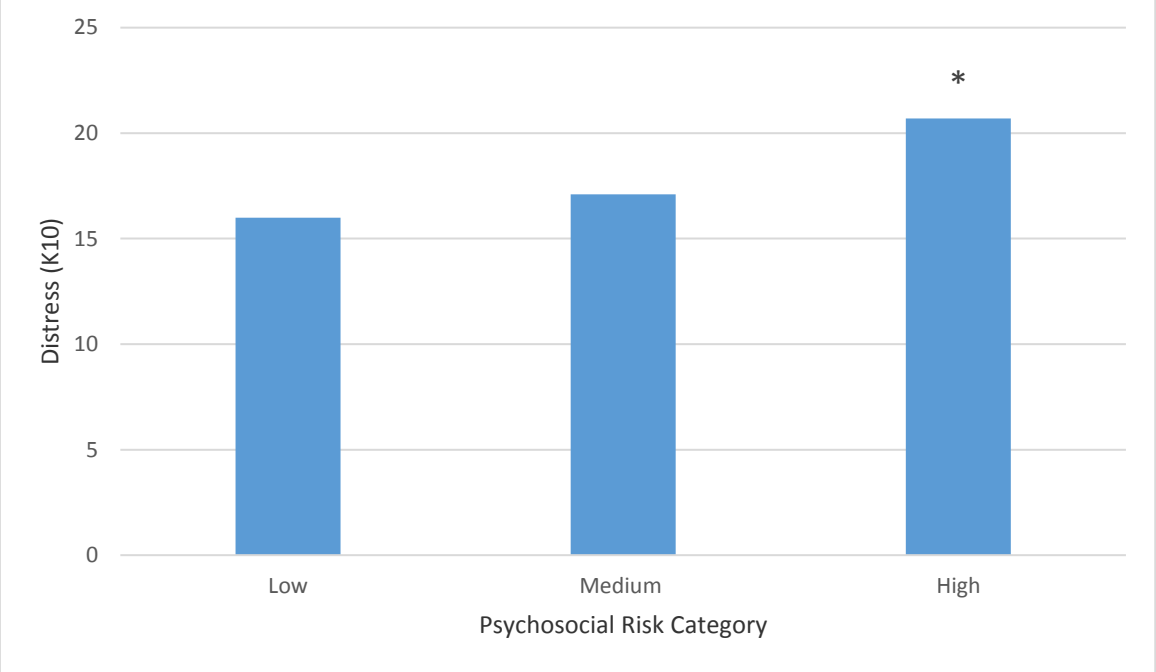


Figure 4. Relationship between psychological distress and psychosocial safety climate risk level.
* denotes significantly greater distress among individuals who fall into the high risk category on the psychosocial climate survey.

Current wellbeing

Health satisfaction

Across all of those who completed the survey, 40% (n = 944) reported feeling satisfied or very satisfied with their health, 44% (n = 1069) felt dissatisfied or very dissatisfied, and 16% (n = 387) felt neither dissatisfied nor satisfied. Health satisfaction did not differ by role.

Quality of life

The majority (64%, n = 1531) of survey respondents reported good or very good quality of life, followed by 22% (n = 528) neither poor nor good, and 15% (n = 341) reported poor or very poor quality of life. Quality of life did not differ by role.

Psychological distress

Across the AFP, the average level of distress reported was in the mild to moderate range (*M*=19.4, *SD*=8.1, range 10-50). When distress level was categorised, 62% of the total sample were scored as likely to be well, 15% as likely to have a mild mental disorder and 23% of respondents scored as being likely to have a moderate or severe mental disorder.

For ease of understanding, these scores were combined for all subsequent analyses to classify respondents as either likely to have ‘no or mild mental health disorder’ (low distress) or likely to have ‘moderate to severe mental health disorder’ (high distress).

There were significant differences in psychological distress by job role (F(2,2342)=6.5, p<.002), location (F(7,2365)=2.9, p=.005) and business area (F(15,2357)=3.2, p<.001). There were, however, no significant differences in psychological distress across age groups, by gender, or by length of service. When examined further, unsworn/professional staff had significantly higher distress than sworn members (*t*(2208)= -3.5, *p*< .001) and distress was significantly lower in International operations than ACT Policing (*t*(453)=4.8, *p*<.001), Support Capability (*t*(404)=-4.4, *p*<.001), and Technology and Innovation (*t*(239)=-3.8, *p*<.001), see

Table 5. There were no significant differences between other business areas. The proportion of respondents in the high distress category (i.e., K10 =>25) was not associated with age, gender, length of service or work location; however associations were observed for job role ($\chi^2(2) = 8.7$, $p = .01$) and business area ($\chi^2(15) = 28.8$, $p = .02$). The proportion of respondents with high distress was higher than expected amongst unsworn staff, those working in ACT Policing and those working in Support Capability.

Table 5. Comparisons of distress (K10) by job role, location and business area

	Distress		
	Mean	SD	*% high distress*[1]
Job role			
Sworn	18.9	7.9	21
Unsworn	20.1	8.1	25
PSO	18.9	8.4	17
Location[2]			
ACT	19.9	8.2	24
NSW	19.1	8.1	22
NT	20.8	10.4	n<5
QLD	18.7	7.9	20
SA	16.8	6.5	13
VIC/TAS[3]	19.2	8.0	23
WA	18.6	7.4	16
International[2]	16.3	6.4	21
Business area			
ACT Policing	21.0	8.6	28
Crime Operations	18.7	8.0	21
Counter Terrorism	17.5	7.0	16

International Operations	17.1	7.3	18
Org. Crime and Cyber	18.7	6.9	18
People, Safety and Security	19.2	7.2	20
Protection Operations	18.8	8.2	18
Specialist Operations	19.8	8.3	23
Support Capability	20.8	8.8	30
Technology and Innovation	21.2	9.1	31
Workforce Development	19.8	6.8	23
Chief of Staff	19.2	7.7	25
Reform, Culture and Standards	19.8	8.6	19
Chief Financial Officer	18.3	7.7	17
Legal	20.7	7.7	28
Other	19.7	8.3	25

[1]High distress reflects a score equal to or greater than 25 on the K10.
[2] Due to small cell sizes, comparisons of the proportion of individuals with high levels of distress by work location could not be examined.
[3]Tasmania and Victoria were combined as there was only one respondent from Tasmania. International includes international missions, posts and external territories.
Note: Green = lower proportions than expected, Red = higher proportion than expected if no association between distress and (1) role and (2) business area (z score =>2).

Relationships between distress and mental health symptoms

Total distress scores were strongly positively correlated with anxiety, depression and PTSD symptoms (.79< *r* <.87, all *p*'s <.001) but only weakly associated with problem alcohol use (*r*=.21, *p*<.001). These findings indicate that scores on the psychological distress measure are generally indicative of mental health problems, but not problematic alcohol use.

Depression symptoms

Depressive symptoms among all respondents were low to moderate (*M*=6.0, *SD*= 5.9, range 0-27). Specifically, using the diagnostic cut-off scores from Konenke et al. (2001), the majority of AFP respondents (82%, n = 1599) were categorised as not having major depressive disorder (MDD). A total of 14% (n = 262) were categorised as likely having MDD, and a small proportion of the sample were categorised as likely having sub-threshold MDD (4%, n = 85).

When investigating symptoms of depression across job roles, total symptom severity was significantly different across roles (F(2,2294)=7.3, *p*= .001). Specifically, unsworn/professional staff reported significantly higher mean depressive symptoms (*M*=6.57, *SD*= 6.00) than sworn members (*M*=5.6, *SD*= 5.7) and PSOs (*M*=5.8, *SD*= 5.9). However, there was no significant difference between job roles in likelihood of diagnosis for MDD.

When looking at rates of MDD within each job role, there was similar proportions of unsworn/professional staff (16%), PSOs (13%) and sworn members (12%) who scored above the cut-off for likely MDD.

A likely diagnosis of MDD was associated with higher levels of functional impairment as measured by the function item of the PHQ (*M*=2.0, *SD*=.8) than those with sub-threshold MDD (*M*=1.2, *SD*=.7) and those with no MDD (*M*=.4, *SD*=.5), F(2,1853)=827.1, *p*<.001. The mean level of functional impairment for those with a likely diagnosis of MDD indicate that these individuals found it 'very difficult' to do daily tasks at work and home.

While suicidality was not specifically assessed, a single item on the PHQ asks whether respondents had be bothered by "thoughts that you would be better off dead or of hurting yourself in some way". Of those who responded to this item (n = 2322), 9% (n = 252) indicated the presence of such thoughts over the past two weeks. This did not vary by gender or role, and due to small cell sizes, could not be examined by location, age or business area.

Sleep

Of those who responded to this item (n = 2322), 41% reported sleep difficulties for several days in the past two weeks, 16% more than half of the days, and 13% nearly every day. Rates of experiencing sleep difficulties at least 50% of the time did not vary by role, age, location or business area, but did vary by gender (p <.05). Specifically, a greater proportion of females (72%) compared to males (67%) experienced sleep difficulties on more than half of the days in the previous two weeks.

Posttraumatic stress symptoms

Two thirds (66%, n = 1502) of the total sample reported having experienced a potentially traumatic event at some point in their life. There was a significant difference between job roles in terms of likelihood of having experienced a potentially traumatic event ($\chi^2(2) = 236.5$, $p < .001$). In particular, sworn members were significantly more likely to have experienced a potentially traumatic event compared to unsworn/professional staff and PSOs. A total of 80% of sworn members had experienced a potentially traumatic event, compared to 56% of PSOs and 49% of unsworn/professional staff.

Overall severity of PTSD symptomatology was low (*M*=14.8, *SD*= 16.2, range 0-80), and below cut off scores associated with PTSD diagnosis (i.e. a score of 33). Of the entire sample, 9% (n = 195) had scores associated with a likely diagnosis of PTSD. When breaking this down by job role, there was a trend level association between severity of PTSD symptoms and role (F(2, 1449)=2.8, *p*=.06 with average PTSD severity scores for unsworn/professional staff of 16.2 (*SD*= 15.9) compared to sworn members of 14.0, (*SD*= 16.1). However, there was a significant difference in having a likely diagnosis of PTSD across job roles ($\chi^2(2) = 10.8$, $p = .005$). A significantly higher proportion of sworn members compared to unsworn/professional staff and PSOs met diagnostic criteria for PTSD.

Specifically, 10% of sworn members had scores indicating a diagnosis of PTSD, compared to 7% of unsworn/professional staff and of PSOs.

Anxiety symptoms

Across the entire AFP sample, the average anxiety symptom severity was low (*M*=4.6, *SD*= 5.0, range 0-21). Overall, 85% (n = 1954) of all respondents were categorised as experiencing low to mild anxiety, 8% (n = 193) as moderate anxiety, and 6% (n = 146) as severe anxiety.

Anxiety symptom severity differed significantly across job roles ($F(2,2265)=8.1$, $p < .001$). Specifically, unsworn/professional staff reported significantly higher anxiety severity (*M*=5.1, *SD*= 5.2) than both sworn members (*M*=4.3, *SD*= 4.8) and PSOs (*M*=4.3, *SD*= 4.9). In line with this finding, job role was associated with being categorised as having severe anxiety ($\chi^2(4) = 13.3$, $p = .01$). A total of 8% of unsworn/professional staff were categorised as experiencing severe anxiety, compared to 6% of PSO and 5% of sworn members. When looking at all those with severe anxiety, 50% were unsworn/professional staff, compared to 45% being sworn members and 5% being PSOs.

Severe levels of anxiety were associated with higher levels of functional impairment (*M*=2.3, *SD*=.7) than those in the moderate (*M*=1.5, *SD*=.7) or low to mild range (*M*=.5, *SD*=.6), $F(2,2132)=813.1$, $p<.001$. The mean level of functional impairment for those with severe anxiety indicate that these individuals found it ‘very difficult’ to do daily tasks at work and home.

Alcohol use

Alcohol misuse was categorised as a binary outcome, specifically a score of 8 or greater is indicative of problematic alcohol use (high risk of harm). Across all staff alcohol use was low (M = 4.0, SD = 2.4). In total, 9% (n = 206) scored above the cut-off indicative of high risk of harm.

When investigated by AFP role, sworn members had higher AUDIT-C scores (*M*=4.4, *SD*= 2.4) than both unsworn/professional (*M*=3.5, *SD*= 2.2) and PSOs (*M*=3.8, *SD*=2.5) who did not differ from one another, $F(2,2197)= 40.5$, $p<.001$. Further, role was associated with AUDIT-C cut-off scores ($\chi^2(2) = 17.2$, $p <0.001$), and adjusted residuals were calculated for each of the cells in order to determine which cell differences contribute to the significant chi square results. Of all those with high-risk alcohol use, there was a much higher proportion of sworn (67%, n = 137) members than unsworn/professional (29%, n = 59) and PSOs (4%, n = 8). Specifically, 12% of all sworn members scored as having high risk of harm on the AUDIT-C, compared to 7% of all unsworn/professional and 6% of all PSOs.

Seeking support

Figure depicts support-seeking preferences for a range of supports among AFP staff if they were experiencing concerns about their work stress or wellbeing. The most likely options for seeking support were from friends or family, or their GP. The least likely was the Confidant

Network, followed by Safe Place. This result needs to be interpreted in light of the specific focus of these services on professional support regarding integrity and professional standards, and bullying and harassment issues respectively. Neither are intended as sources of support to staff experiencing work related stress or wellbeing more broadly. Excepting these two forms of support, the next least likely services were Chaplains followed by Davidson Trahaire Corppsych (EAP).

Figure 5. Support seeking preferences of all AFP respondents (n=2235)

Support seeking preferences were examined by level of distress (i.e., low, high). Support seeking preferences among respondents with high distress are depicted in Figure . Chi square tests revealed associations between distress level and several support seeking preferences (all *p*'s <0.05). Adjusted residuals were calculated and showed that there were higher proportions of employees with high distress who identified a positive preference (i.e., rated as 'likely' or 'very likely') to seek support from private psychologists and google/online tools. On the other hand, a higher proportion of these same respondents indicated a negative preference (i.e., that they were either 'unlikely' or 'very unlikely') to see seek help from

friends and family, colleagues, managers, AFP Psychological Services, Confidant Network, Safe Place and the EAP.

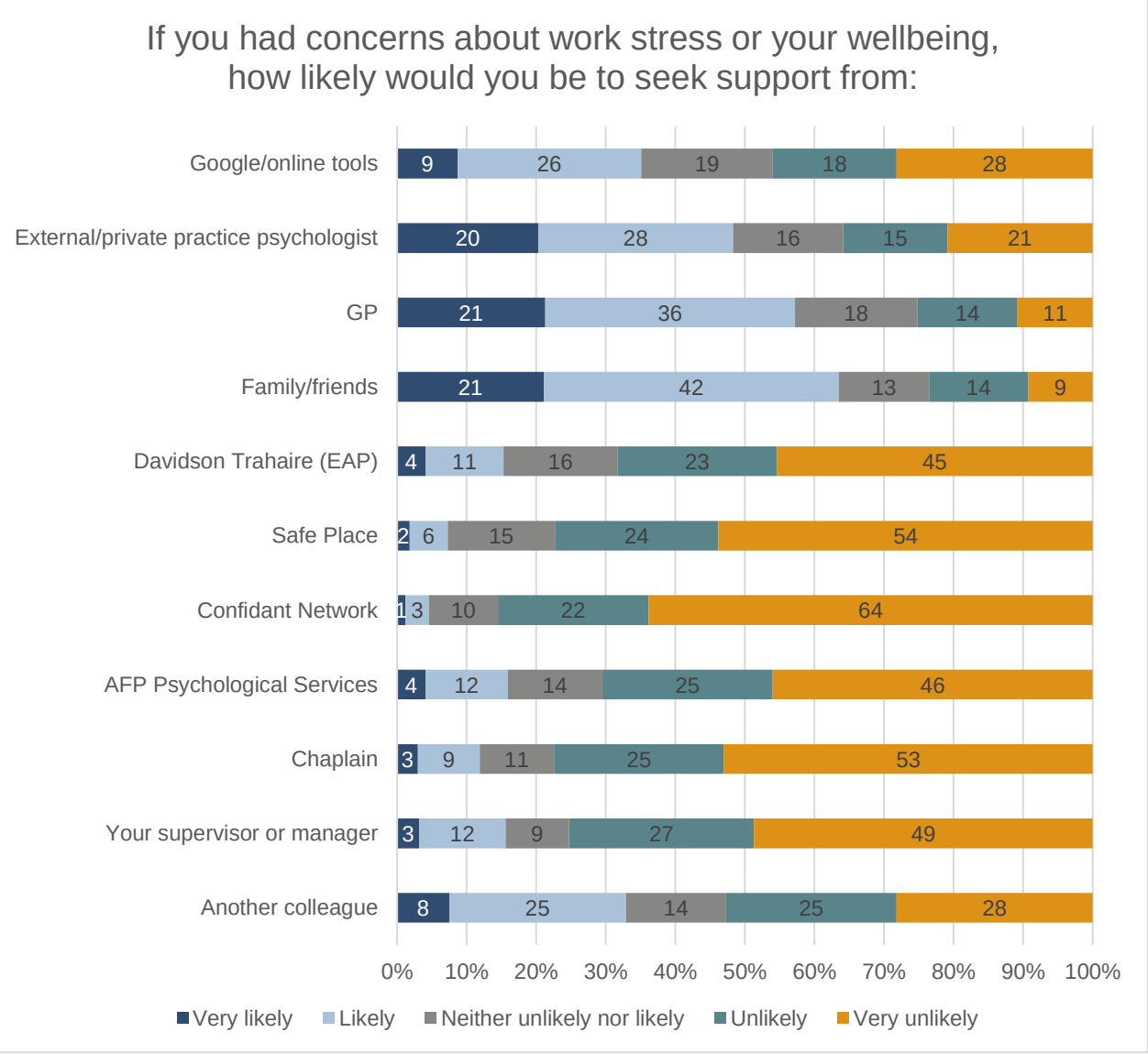


Figure 6. Support seeking preferences among respondents (n=507) with high distress (i.e., K10=>25).

Support seeking preferences by role are available in *Appendix 0-6.* Chi square tests could not be performed due to low expected cell counts.

Chi square tests revealed differences in support seeking preferences by role for most types of supports (*p*'s <.05), except seeking help from an external/private psychologist or from a colleague (*p*'s>.05; i.e., all roles were equally likely to see support from these sources). Results from follow up tests examining adjusted residuals are reported in Table 6.

Table 6. Support seeking preferences by role

Support type	Preference type	Sworn	Unsworn Professional	PSO
Another colleague	% Positive	46%	52%	48%
	% Negative	38%	34%	40%
Your supervisor or manager	% Positive	29%	36%	34%
	% Negative	58%	51%	54%
Chaplain	% Positive	16%	13%	25%
	% Negative	71%	71%	62%
AFP Psychological Services	% Positive	20%	25%	22%
	% Negative	65%	56%	58%
Family/friends	% Positive	75%	78%	69%
	% Negative	15%	12%	22%
GP	% Positive	49%	58%	61%
	% Negative	30%	25%	21%
External psychologist	% Positive	35%	38%	40%
	% Negative	45%	42%	36%
Google/online tools	% Positive	26%	33%	24%
	% Negative	55%	47%	54%
Davidson Trahaire (EAP)	% Positive	19%	22%	27%
	% Negative	63%	57%	59%
Confidant Network	% Positive	6%	11%	12%
	% Negative	81%	73%	77%
Safe Place	% Positive	8%	13%	11%
	% Negative	76%	65%	71%

Green = lower proportions than expected, Red = higher proportion than expected if no association between role and preference for each support type (z score =>2).
Note: For this analysis, responses of 'likely' or 'very likely' and 'unlikely' or 'very unlikely' were combined to create two variables indicating the type of preference: 'positive 'and 'negative'.

Barriers to seeking support

Participants were presented with ten common barriers to help seeking and asked to rate whether such barriers were a concern to their own help seeking behaviours. Responses to barriers are presented in Figure 7.The top three barriers involved concerns about putting one's career at risk (32% rated as a definite concern), fears that confidentiality will not be

respected (31%) and concerns that people will have less confidence in me (24%). Only 2% of respondents reported that knowledge about where to get help was a definite concern.

The level of concern regarding each barrier among respondents with high distress (n = 503) are depicted in Figure . Chi square tests revealed associations between high distress and perceptions of all ten barriers (all *p*'s <0.05). While the rank order of barriers among respondents with high distress was similar to those of the AFP overall, calculation of adjusted residuals revealed that there were higher proportions of respondents with high distress who reported moderate or definite concerns about all of the ten listed barriers to help seeking compared to those with low distress. These findings suggest that higher levels of distress increase perceptions of barriers to seeking help.

Perceptions of barriers by role are available in *Appendix 0-7.*

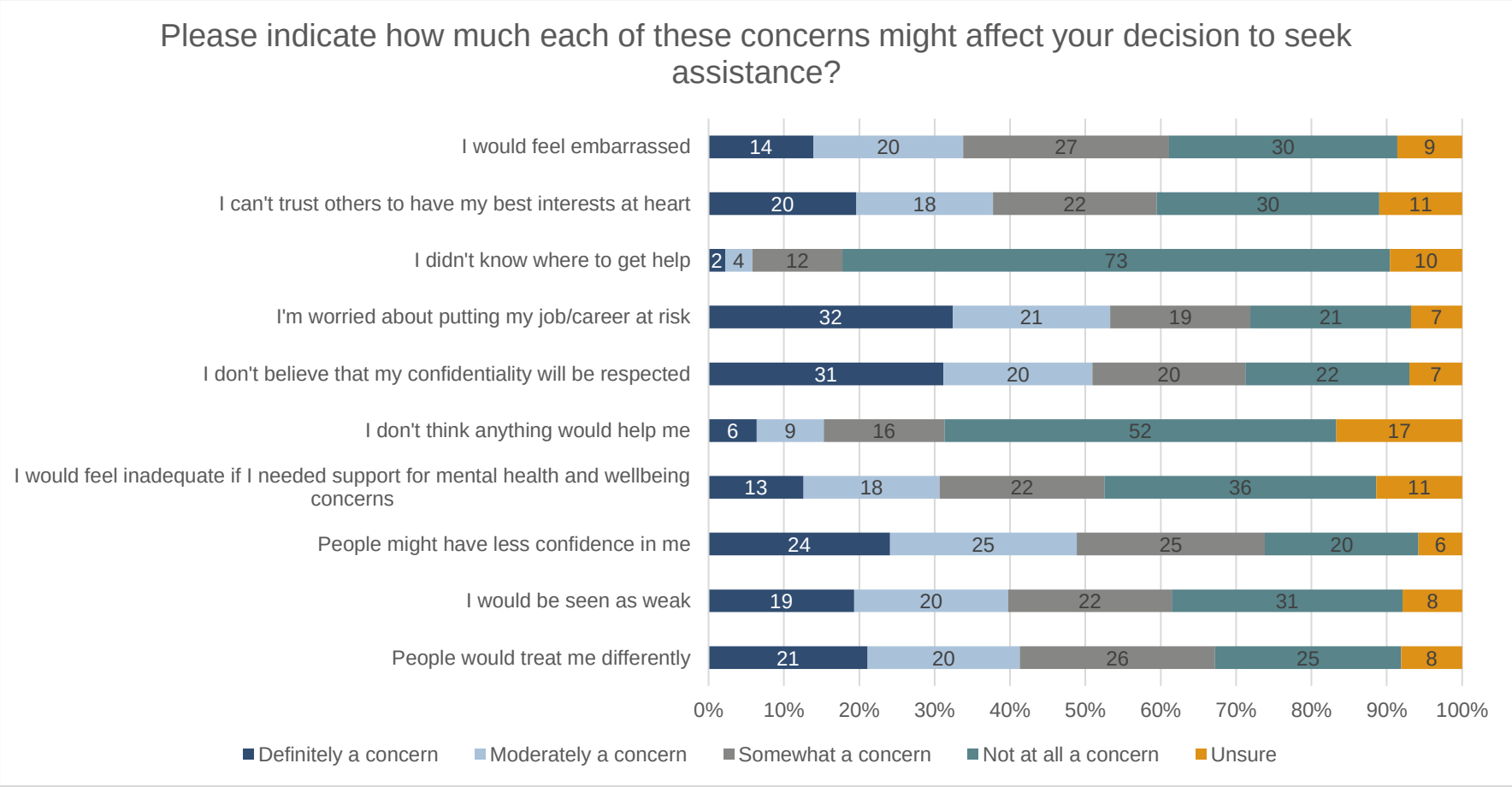


Figure 7. Concerns and barriers to help seeking among AFP respondents (n=2216)

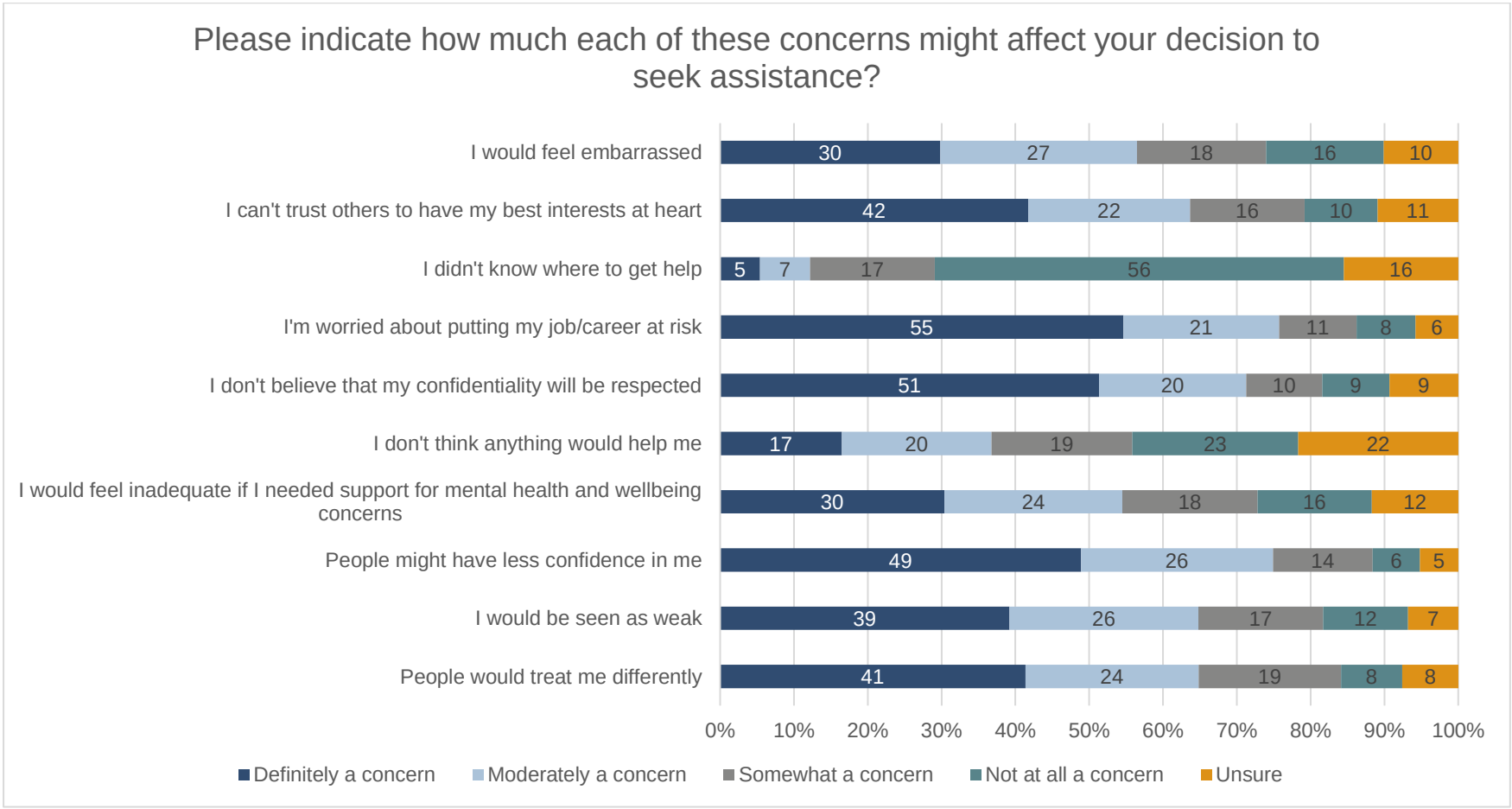


Figure 8. Concerns and barriers to help seeking among respondents (n=503) with K10 scores in the moderate to severe (25+) range.

Help received in past year

The numbers of respondents who consulted each source of AFP support and the mean rating scores for helpfulness and ease of access are depicted in Table 7. Chaplains were rated as being the most helpful, followed by external providers then ACT welfare officers. The ACT welfare officers were considered the most accessible, followed by chaplains then external providers.

Table 7. AFP supports sought during the past year

Support	Yes (% total responses)		Distress		Usefulness	Ease of access[1]
			K10 <25	K10 =>25		
AFP psych services	389	(18%)	11%	6%	2.80	3.09
EAP	187	(9%)	5%	4%	2.52	3.37
Chaplain	147	(7%)	5%	2%	3.73	3.83
Confidant Network	120	(6%)	3%	2%	2.85	3.49
Safe Place	180	(8%)	5%	3%	2.64	3.51
ACT welfare officers	113	(5%)	3%	2%	3.63	3.94
External provider	643	(29%)	16%	13%	3.70	3.81

[1] Scores on usefulness and ease of access were ratings from 1 ('not at all') and 5 ('extremely'), such that higher scores were associated with more positive views of this support service

The number of respondents who consulted each source of AFP support, mean ratings of helpfulness and ease of access by role, gender, age and location are depicted in *Appendix 0-8.*

We conducted further investigations into the number of people using welfare support services excluding the Confidant Network and Safe Place, given that the role of these internal services are not explicitly focused on mental health. 953 respondents identified seeking support from at least one of the five remaining sources (i.e., AFP Psychological services, EAP, chaplains, ACT welfare officers, external provider) and the average number of sources of support used was 1.6 (*SD* = .79). The average number of supports used by people who sought help did not differ by role, gender, location and business area, suggesting that the same help seeking pattern is generally consistent across the organisation. Of the respondents who used an external psychologist (n = 643), just under half (47%, n = 305) also used a service provided by the AFP.

Organisational commitment

Among respondents, 8% (n = 181) reported extremely high levels of job satisfaction, 36% (n = 789) reported being very satisfied with their job, 34% (n = 753) somewhat, 13% (n = 284) slightly and 9% (n = 194) not at all satisfied with their job. Levels of organisational commitment were high, with 29% (n = 626) reporting being extremely committed to the organisation, 39% (n = 847) very committed to the organisation, 18% (n = 394) somewhat, 9% (n = 204) slightly, and 6% (n = 127) not at all committed to the organisation.

The means and standard deviations for job satisfaction and organisational commitment by role, gender, age and location are depicted in Table 8.

Females report higher job satisfaction than males ($F(2,2198)= 4.7$, $p=0.009$), as well as greater organisational commitment than both males and those who identified as other/prefer not to say ($F(2,2195)=23.2$, $p<.001$).

Unsworn/professional staff report higher job satisfaction than sworn members, but not PSOs ($F(2,2172)=5.6$, $p=.004$). Unsworn/professional staff have higher organisational commitment than both sworn members and PSOs ($F(2,2169)=32.8$, $p<.001$).

When examined by location, job satisfaction was significantly higher among staff working internationally compared to ACT, NSW, VIC/TAS, QLD and WA ($F(7,2193) = 4.6$, $p<.001$). Organisational commitment was higher among those working internationally than those in NSW, QLD and VIC/TAS, and higher in the ACT compared to both QLD and NSW ($F(7, 2197 = 6.6$, $p<.001$).

Table 8. Mean scores for job satisfaction and organisational commitment by role, gender, age and location

	Job satisfaction		Organisational Commitment	
	Mean	**SD**	**Mean**	**SD**
All AFP	3.22	1.06	3.75	1.14
Role				
Sworn	3.16	1.08	3.57	1.22
Unsworn/Professional	3.31	1.00	3.98	0.96
PSO	3.15	1.26	3.68	1.25
Gender				
Male	3.16	1.08	3.63	1.19
Female	3.30	1.02	3.93	1.01
Other/Prefer not to say	3.09	1.21	3.35	1.47
Age				
18 to 24	3.63	1.04	4.26	0.71
25 to 34	3.22	1.02	3.71	1.12
35 to 44	3.20	1.04	3.74	1.12
45 to 54	3.19	1.09	3.73	1.17
55+	3.30	1.09	3.84	1.13
Location				
ACT	3.26	1.05	3.84	1.08
NSW	3.06	1.05	3.50	1.21
NT	3.19	1.17	4.19	0.83
QLD	3.11	1.13	3.55	1.19
SA	3.44	0.91	3.89	1.14
VIC & TAS	3.17	1.04	3.61	1.19
WA	3.13	1.08	3.70	1.20
International	3.89	0.81	4.25	0.97

When asked about how long they intend to continue their employment at the AFP, 25% (n = 557) reported less than 5 years, 24% (n = 523) said 5- 9 years, 21% (n = 462) said they plan

to stay for 20 or more years, 19% (n = 421) said 10 – 14 years, and 11% (n = 238) reported 15 – 19 years. Responses by gender and role are also depicted in Figure .

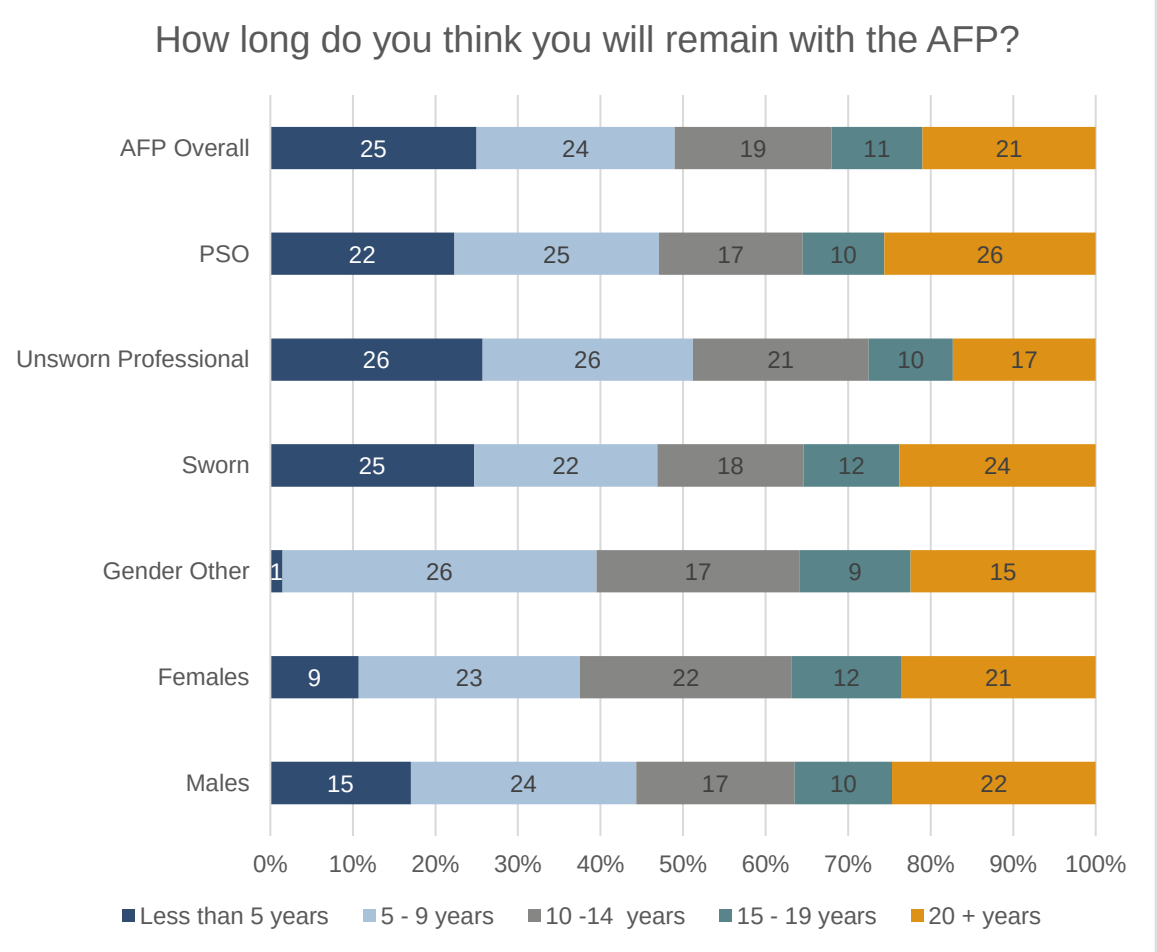


Figure 9. Plans to stay with the AFP by role and gender.

Appendices to survey results

Appendix 0-1: Response rates by demographics

Note: The response rates are taken as a percentage of head count numbers and exclude personnel designated as contractors and other employees.

Respondent and response rate by age

Age category	Number	% of respondents	Response rate %
18 to 24	41	1	32
25 to 34	546	19	37
35 to 44	1029	35	44
45 to 54	995	34	49
55 to 64	322	11	54
65 to 74	19	<1	46
75 or older	1	<1	100

Respondent and response rate by gender

Gender	Number	% of respondents	Response rate %
Female	1598	54	68
Male	1251	42	30
Indeterminate/Intersex/Unspecified	12	<1	-
Prefer not to say	92	3	-

Respondent and response rate by marital status

Marital status	Number	% of respondents	Response rate %
Single (never married)	461	16	-

Married	1706	58	-
De Facto	454	15	-
Separated / Divorced	317	11	-
Widowed	15	<1	-

Respondent and response rate by length of service

Years of service	Number	% of respondents	Response rate %
Less than a year	56	2	27
1-2 years	119	4	26
3-5 years	361	12	43
6-10 years	751	26	36
11-19 years	1135	39	51
20-29 years	316	11	65
30+ years	186	6	71

Respondent and response rate by employment category

Service type	Number	% of respondents	Response rate %
Sworn member	1487	51	44
Professional / Unsworn	1227	42	50
PSO	173	6	25
Contractor	24	<1	-
Other	13	<1	-

Respondent and response rate by work location

Location	Number	% of respondents	Response rate %
ACT	1652	57	45
New South Wales	444	15	43
Northern Territory	23	<1	30
Queensland	217	8	51
South Australia	51	2	41
Tasmania	1	<1	20
Victoria	311	11	46
Western Australia	155	5	51
Overseas			22
International missions	30	1	-
International posts	20	<1	-
External territories	4	<1	-

Respondent and response rate by business area

Location	Number	% of respondents	Response rate %
ACT Policing	347	12	39.5
Crime Operations	279	9.7	65
Counter Terrorism	106	3.7	46.2
International Operations	192	6.7	43.6
Org. Crime and Cyber	241	8.4	50.1
People, Safety and Security	181	6.3	59.3
Protection Operations	396	13.7	30.5
Specialist Operations	248	8.6	48.2
Support Capability	304	10.5	36.7
Technology and Innovation	96	3.3	39.1
Workforce Development	155	5.4	48.3
Chief of Staff	45	1.6	19.5
Reform, Culture and Standards	51	1.8	48.5
Chief Financial Officer	63	2.2	28.9
Legal	49	1.7	47
Other	132	4.6	-

Respondent and response rate by business area

Location	Number	% of respondents	Response rate %
ACT Policing	347	12	40
Crime Operations	279	10	65
Counter Terrorism	106	4	46
International Operations	192	7	44
Org. Crime and Cyber	241	8	50
People, Safety and Security	181	6	60
Protection Operations	396	14	31
Specialist Operations	248	9	48
Support Capability	304	11	37
Technology and Innovation	96	3	39
Workforce Development	155	5	48
Chief of Staff	45	2	20
Reform, Culture and Standards	51	2	49
Chief Financial Officer	63	2	29
Legal	49	2	47
Other	132	5	-

Appendix 0-2. Sources of stress by role

Mean scores of operational stressors by role

	Sworn		Unsworn/ Professional		PSO		Total AFP	
	Mean (SD)	**N/A%**	**Mean (SD)**	**N/A%**	**Mean (SD)**	**N/A%**	**Mean (SD)**	**N/A %**
Shift work	3.19 (1.97)	17.0	2.09 (1.67)	59.4	3.33 (1.88)	7.3	2.91 (1.95)	34.1
Working alone at night	2.28 (1.80)	29.1	1.86 (1.53)	56.1	2.19 (1.66)	25.6	2.15 (1.72)	40.2
Over-time demands	3.06 (1.91)	10.3	2.60 (1.85)	39.3	2.22 (1.67)	12.2	2.85 (1.9)	22.5
Risk of being injured on the job	3.02 (1.90)	4.0	2.01 (1.56)	30.2	2.93 (1.90)	3.0	2.66 (1.86)	14.9
Work related activities on days off (e.g., court, community events)	3.34 (1.99)	8.2	2.09 (1.60)	43.0	1.90 (1.44)	17.7	2.85 (1.94)	23.4
Traumatic events (e.g. MVA, domestics, death, injury)	2.85 (1.99)	14.2	2.23 (1.74)	45.4	2.36 (1.81)	14.6	2.61 (1.92)	27.3
Managing your social life outside of work	3.32 (1.90)	0.7	2.49 (1.65)	7.2	2.96 (1.85)	1.8	2.95 (1.84)	3.5
Not enough time available to spend with friends and family	3.70 (1.95)	0.7	2.74 (1.79)	7.0	3.11 (1.94)	1.8	3.27 (1.95)	3.4
Paperwork	**4.26 (1.95)**	0.8	**3.41 (1.89)**	3.3	2.66 (1.70)	2.4	**3.81 (1.98)**	2
Eating healthy at work	3.42 (1.94)	0.7	2.84 (1.74)	2.2	3.37 (1.93)	1.2	3.18 (1.88)	1.4
Finding time to stay in good physical condition	**4.15 (1.93)**	0.7	**3.68 (1.94)**	1.7	**3.78 (2.06)**	2.4	**3.93 (1.96)**	1.2
Fatigue (e.g. shift work, over-time)	**4.04 (2.03)**	3.9	**3.17 (2.00)**	22.5	**3.94 (2.12)**	4.3	**3.71 (2.07)**	11.7

Occupation-related health issues (e.g. back pain)	3.65 (2.07)	3.2	3.13 (1.93)	9.6	**4.02 (2.12)**	1.8	3.46 (2.04)	5.8
Lack of understanding from family and friends about your work	2.89 (1.87)	1.4	2.35 (1.70)	8.4	3.06 (1.99)	2.4	2.68 (1.83)	4.4
Making friends outside the job	2.80 (1.91)	2.1	2.22 (1.73)	8.9	2.89 (1.98)	3.0	2.57 (1.87)	5
Upholding a "higher image" in public	2.75 (1.89)	1.3	1.96 (1.49)	8.3	2.63 (1.88)	1.8	2.43 (1.78)	4.2
Negative comments from the public	2.61 (1.77)	1.2	1.91 (1.42)	9.8	2.44 (1.72)	1.8	2.33 (1.68)	4.8
Limitations to your social life (e.g. who your friends are, where you socialise)	2.96 (1.93)	1.3	2.15 (1.63)	6.8	2.96 (1.94)	2.4	2.63 (1.86)	3.7
Feeling like you are always on the job	3.75 (2.02)	1.1	2.47 (1.81)	8.9	2.91 (1.91)	3.7	3.18 (2.03)	4.5
Friends/family feel the effects of the stigma associated with your job	2.69 (1.87)	2.4	1.88 (1.47)	10.1	2.65 (1.91)	2.4	2.36 (1.77)	5.6

Note: **Red** = top 3 highest rated items.

Mean scores of organisational stressors by role

	Sworn		Unsworn/Professional		PSO		All AFP	
	Mean (SD)	N/A%	Mean (SD)	N/A%	Mean (SD)	N/A%	Mean (SD)	N/A%
Dealing with co-workers	4.07 (1.78)	0.1	4.14 (1.83)	0.2	4.15 (1.88)	0.0	4.09 (1.81)	0.1
The feeling that different rules apply to different people (e.g. favouritism)	**4.93 (1.92)**	0.5	**4.53 (2.01)**	0.5	**5.20 (1.99)**	0.6	**4.77 (1.98)**	0.5
Feeling like you always have to prove yourself to the organisation	4.36 (1.97)	0.7	4.00 (2.06)	0.8	4.36 (2.09)	1.3	4.2 (2.02)	0.8
Excessive administrative duties	4.34 (1.97)	0.8	3.52 (1.99)	1.7	2.93 (1.84)	3.2	3.91 (2.02)	1.3
Constant changes in policy/legislation	3.78 (1.92)	0.6	2.99 (1.79)	2.2	3.34 (2.04)	1.3	3.42 (1.91)	1.3
Staff shortages	**5.01 (1.92)**	1.4	**4.87 (2.01)**	1.2	3.99 (2.15)	0.6	**4.88 (1.99)**	1.3
Bureaucratic red tape	**4.92 (1.85)**	1.4	4.14 (1.99)	2.2	**4.44 (2.16)**	0.6	**4.56 (1.97)**	1.7
Too much computer work	4.03 (1.96)	0.8	3.12 (1.90)	1.5	2.60 (1.67)	0.5	3.56 (1.99)	1.1
Lack of training on new equipment	3.46 (2.00)	1.6	2.78 (1.88)	5.4	3.24 (2.03)	1.3	3.17 (1.98)	3.2
Perceived pressure to volunteer free time	3.49 (2.13)	3.0	2.38 (1.85)	8.3	2.44 (1.80)	5.1	2.97 (2.07)	5.3
Dealing with supervisors	3.84 (2.04)	0.5	3.56 (2.07)	0.7	3.73 (2.20)	1.3	3.71 (2.06)	0.6
Inconsistent leadership style	4.67 (2.08)	1.8	4.28 (2.17)	1.2	**4.74 (2.09)**	1.9	4.54 (2.13)	1.6
Lack of resources	4.67 (2.00)	1.1	**4.30 (2.11)**	1.8	3.66 (1.98)	1.3	4.44 (2.07)	1.4
Unequal sharing of work responsibilities	4.17 (2.07)	1.1	3.99 (2.20)	1.7	3.58 (2.08)	1.3	4.05 (2.13)	1.3

If you are sick or injured your co-workers seem to look down on you	2.72 (1.99)	5.7	2.69 (2.09)	5.8	2.79 (1.97)	3.8	2.7 (2.02)	5.6
Leaders over-emphasise the negatives (e.g. supervisor evaluations, public complaints)	3.42 (2.15)	2.7	2.86 (2.07)	4.4	3.68 (2.24)	3.2	3.2 (2.14)	3.4
Internal investigations	2.75 (2.08)	8.0	2.01 (1.74)	23.0	2.83 (2.15)	10.8	2.47 (1.99)	14.4
Dealing with the court system	2.90 (1.87)	6.3	1.85 (1.52)	46.6	1.73 (1.37)	28.0	2.51 (1.81)	24.5
The need to be accountable for doing your job	2.93 (1.90)	0.5	2.55 (1.84)	2.6	2.78 (1.95)	1.3	2.76 (1.89)	1.4
Inadequate equipment / systems	3.74 (2.02)	0.7	3.39 (2.04)	4.0	0.00 (1.88)	1.3	3.55 (2.03)	2.1

Note: **Red** = top 3 highest rated items.

Appendix 0-3. Frequency of exposure to critical incidents by role type

Critical incident description		Job type		
		Sworn	Unsworn	PSO
	Frequency	%	%	%
Serious threat, assault, sexual assault or injury to another AFP staff member, including exposure to toxin/bodily fluid	Never	77%	95%	92%
	1 - 2 times	16%	4%	6%
	3 - 5 times	4%	<1%	1%
	6+ times	4%	1%	1%
Serious threat, assault, sexual assault or injury to yourself, including exposure to toxin/bodily fluid	Never	81%	97%	91%
	1 - 2 times	14%	2%	6%
	3 - 5 times	2%	1%	1%
	6+ times	3%	<1%	1%
Exposure to a horrific injury or accident scene	Never	79%	94%	91%
	1 - 2 times	14%	5%	6%
	3 - 5 times	5%	1%	<1%
	6+ times	3%	1%	3%
Responded or were involved in a terrorism-related event	Never	74%	86%	86%
	1 - 2 times	19%	9%	13%
	3 - 5 times	5%	3%	1%

Critical incident description		Job type		
		Sworn	Unsworn	PSO
	Frequency	%	%	%
	6+ times	2%	2%	1%
Administered emergency first aid (e.g. resuscitation)	Never	89%	98%	89%
	1 - 2 times	9%	2%	1<1%
	3 - 5 times	1%	<1%	1%
	6+ times	1%	<1%	1%
Attended a major or significant incident where victims were known to you, or you identified with victim	Never	92%	99%	96%
	1 - 2 times	7%	1%	3%
	3 - 5 times	1%	<1%	<1%
	6+ times	<1%	<1%	1%
Major or significant incident where police response is complex or protracted	Never	57%	88%	88%
	1 - 2 times	29%	8%	9%
	3 - 5 times	8%	3%	1%
	6+ times	6%	1%	2%
Responded or were involved with a case that had a fatality (including suicide and multiple fatalities)	Never	77%	9<1%	94%
	1 - 2 times	15%	6%	5%
	3 - 5 times	5%	2%	1%

Critical incident description		Job type		
		Sworn	Unsworn	PSO
	Frequency	%	%	%
	6+ times	3%	2%	1%
Serious case of child abuse/neglect	Never	84%	93%	95%
	1 - 2 times	1<1%	4%	3%
	3 - 5 times	3%	1%	<1%
	6+ times	3%	2%	2%
Child sexual abuse	Never	85%	92%	96%
	1 - 2 times	1<1%	4%	2%
	3 - 5 times	2%	1%	<1%
	6+ times	3%	3%	2%
Viewed objectionable material, such as child exploitation material or terrorism-related images	Never	75%	83%	88%
	1 - 2 times	14%	8%	8%
	3 - 5 times	4%	4%	1%
	6+ times	7%	6%	4%
Responded or were involved in a case that concerned extreme acts of cruelty, such as human trafficking, torture, or brutal violence	Never	83%	91%	94%
	1 - 2 times	11%	4%	3%
	3 - 5 times	3%	2%	<1%

Critical incident description		Job type		
		Sworn	Unsworn	PSO
	Frequency	%	%	%
	6+ times	3%	3%	3%
Death or injury of a community member resulting from police action	Never	96%	99%	99%
	1 - 2 times	3%	1%	1%
	3 - 5 times	<1%	<1%	<1%
	6+ times	<1%	<1%	1%
High profile event leading to internal investigation and/or critical media attention	Never	75%	87%	91%
	1 - 2 times	19%	1<1%	7%
	3 - 5 times	4%	2%	1%
	6+ times	2%	1%	1%
Death of an AFP member in the line of duty	Never	98%	99%	96%
	1 - 2 times	2%	1%	3%
	3 - 5 times	<1%	<1%	<1%
	6+ times	<1%	<1%	1%
Death of an AFP member from suicide	Never	83%	87%	89%
	1 - 2 times	17%	12%	1<1%
	3 - 5 times	<1%	1%	<1%
	6+ times	<1%	<1%	1%

Critical incident description		Job type		
		Sworn	Unsworn	PSO
	Frequency	%	%	%
Serious case of animal cruelty	Never	95%	96%	99%
	1 - 2 times	4%	4%	<1%
	3 - 5 times	1%	1%	1%
	6+ times	<1%	<1%	1%
Involvement in riot or crowd control in which people were injured	Never	96%	10<1%	95%
	1 - 2 times	3%	<1%	3%
	3 - 5 times	1%	<1%	1%
	6+ times	1%	<1%	1%
Other work related event that results in a traumatic stress reaction for you	Never	83%	88%	91%
	1 - 2 times	11%	7%	5%
	3 - 5 times	3%	3%	1%
	6+ times	3%	2%	3%
Exposure to a natural disaster, which may or may not have resulted in death	Never	97%	99%	96%
	1 - 2 times	2%	1%	2%
	3 - 5 times	1%	<1%	1%
	6+ times	<1%	<1%	1%

Appendix 0-4. Bullying by business area

Bullying by business area

Business area	Number of respondents who answered bullying question	% of bullied from total respondents in business area	
ACT Policing	316	29%	n=93
Crime Operations	242	24%	n=58
Counter Terrorism	89	20%	n=18
International Operations	169	22%	n=37
Org. Crime and Cyber	208	17%	n=36
People, Safety and Security	160	23%	n=36
Protection Operations	355	36%	n=126
Specialist Operations	219	23%	n=50
Support Capability	268	35%	n=93
Technology and Innovation	85	25%	n=21
Workforce Development	140	31%	n=43
Chief of Staff	42	26%	n=11
Reform, Culture and Standards	45	N/A	n<5
Chief Financial Officer	56	16%	n=9
Legal	42	17%	n=7
Other	113	27%	n=30

Green = lower proportions than expected, Red = higher proportion than expected if no association between business area and bullying (z score =>2).

Appendix 0-5. Psychosocial climate risk category by role and business area

Role	Number of respondents who completed PSC	Low risk (%)	Moderate risk (%)	High risk (%)
Sworn	1286	14.3%	9.6%	76.0%
Unsworn/Professional	1004	24.9%	14.1%	61.0%
PSO	149	12.1%	9.4%	78.5%

Green = lower proportions than expected, Red = higher proportion than expected if no association between role and PSC-Cut off (z score =>2).

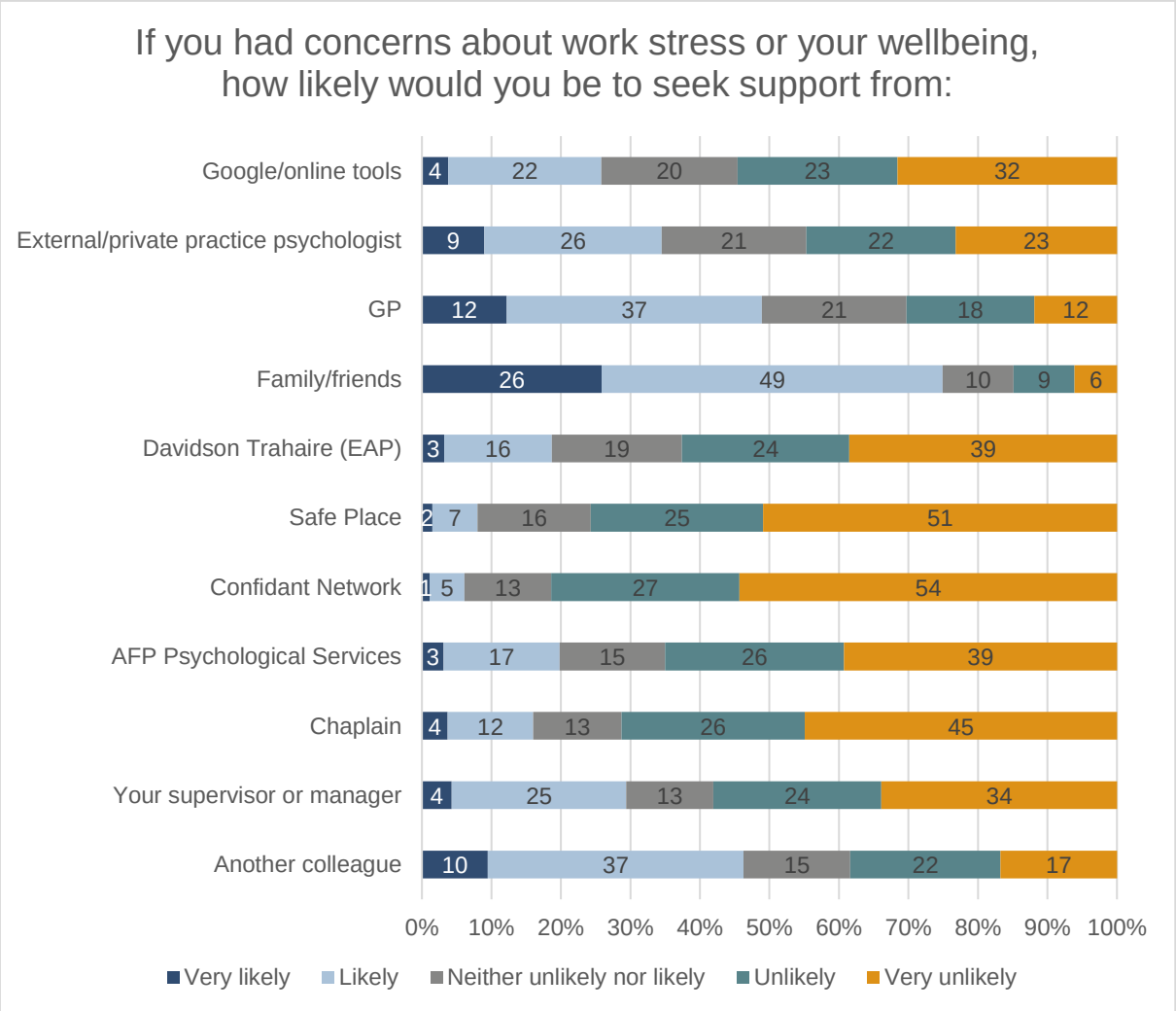
Business area	Number of respondents who completed PSC	% Low risk	%Moderate risk	% High risk
ACT Policing	310	7%	8%	85%
Crime Operations	236	17%	15%	69%
Counter Terrorism	88	30%	11%	59%
International Operations	165	29%	12%	59%
Org. Crime and Cyber	203	16%	13%	70%
People, Safety and Security	147	26%	12%	63%
Protection Operations	342	12%	7%	80%
Specialist Operations	216	18%	15%	68%
Support Capability	256	11%	9%	80%
Technology and Innovation	82	26%	18%	56%

Workforce Development	134	22%	10%	69%
Chief of Staff	42	33%	21%	45%
Reform, Culture and Standards	44	39%	11%	50%
Chief Financial Officer	54	48%	15%	37%
Legal	40	28%	15%	58%
Other	110	26%	12%	62%

Chi Square tests could not be performed due to low expected cell counts.

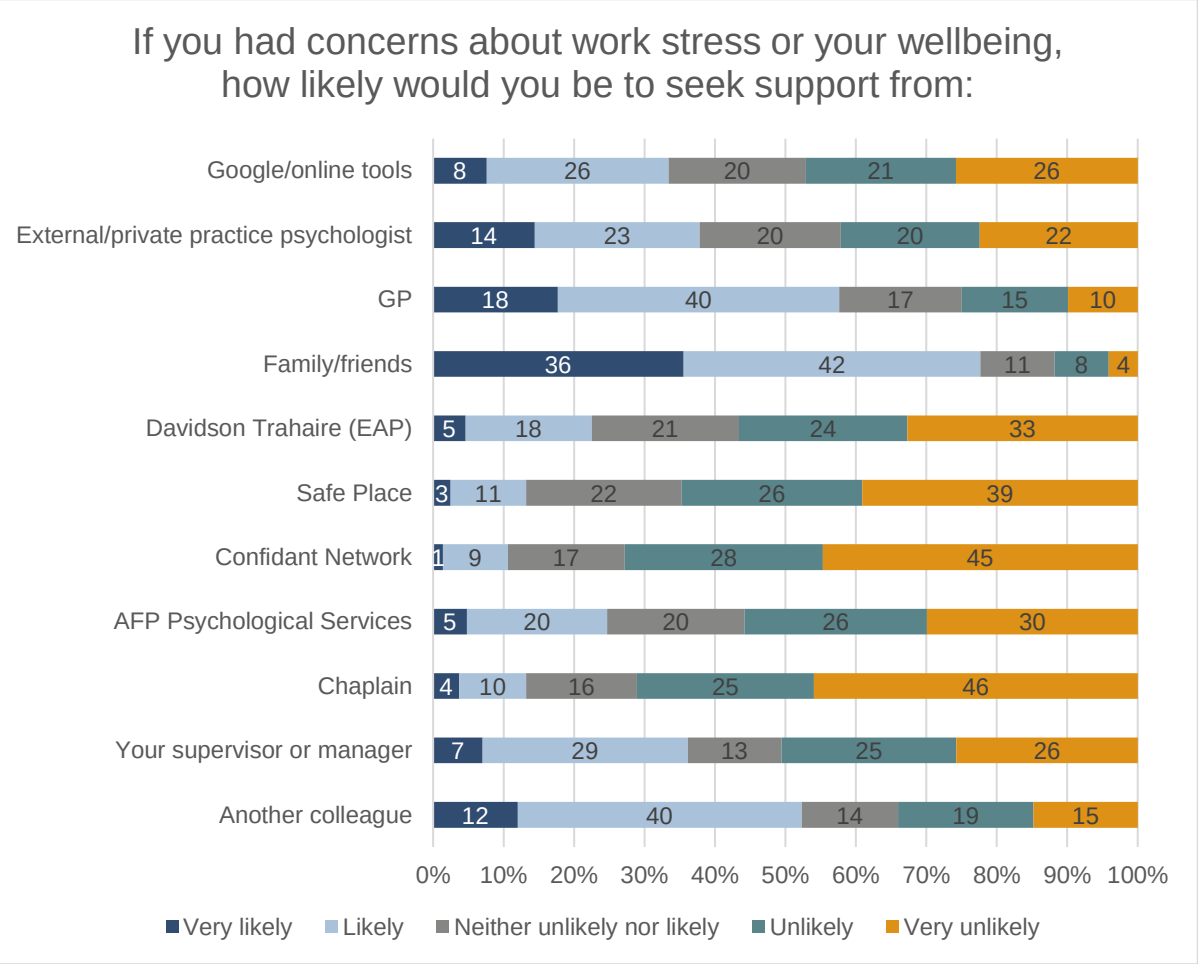
Appendix 0-6. Support seeking preferences by role

Sworn members (N=1164)



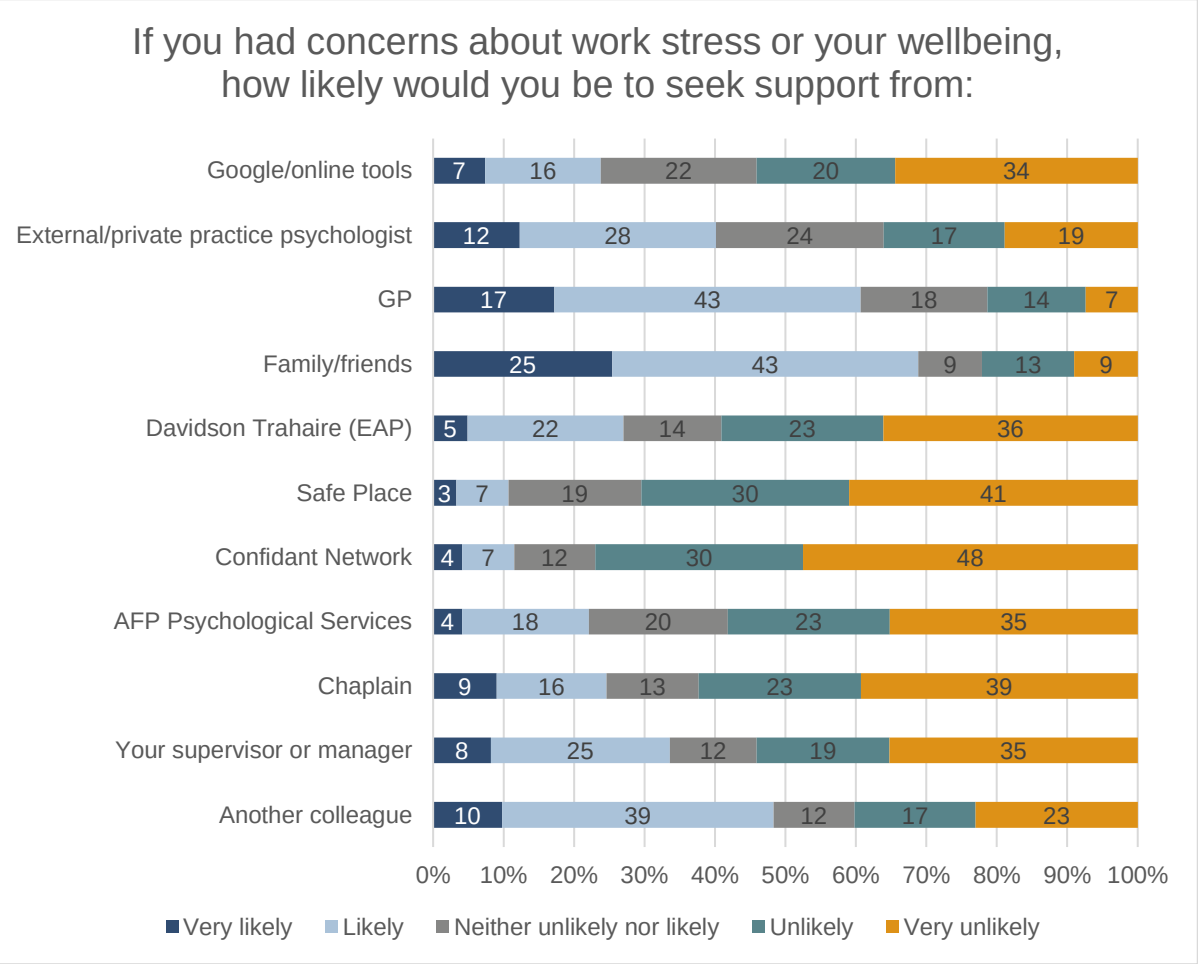
Support seeking preferences of sworn respondents (n=1164)

Unsworn/professional staff (N=923)



Support seeking preferences of unsworn/professional respondents (n=923)

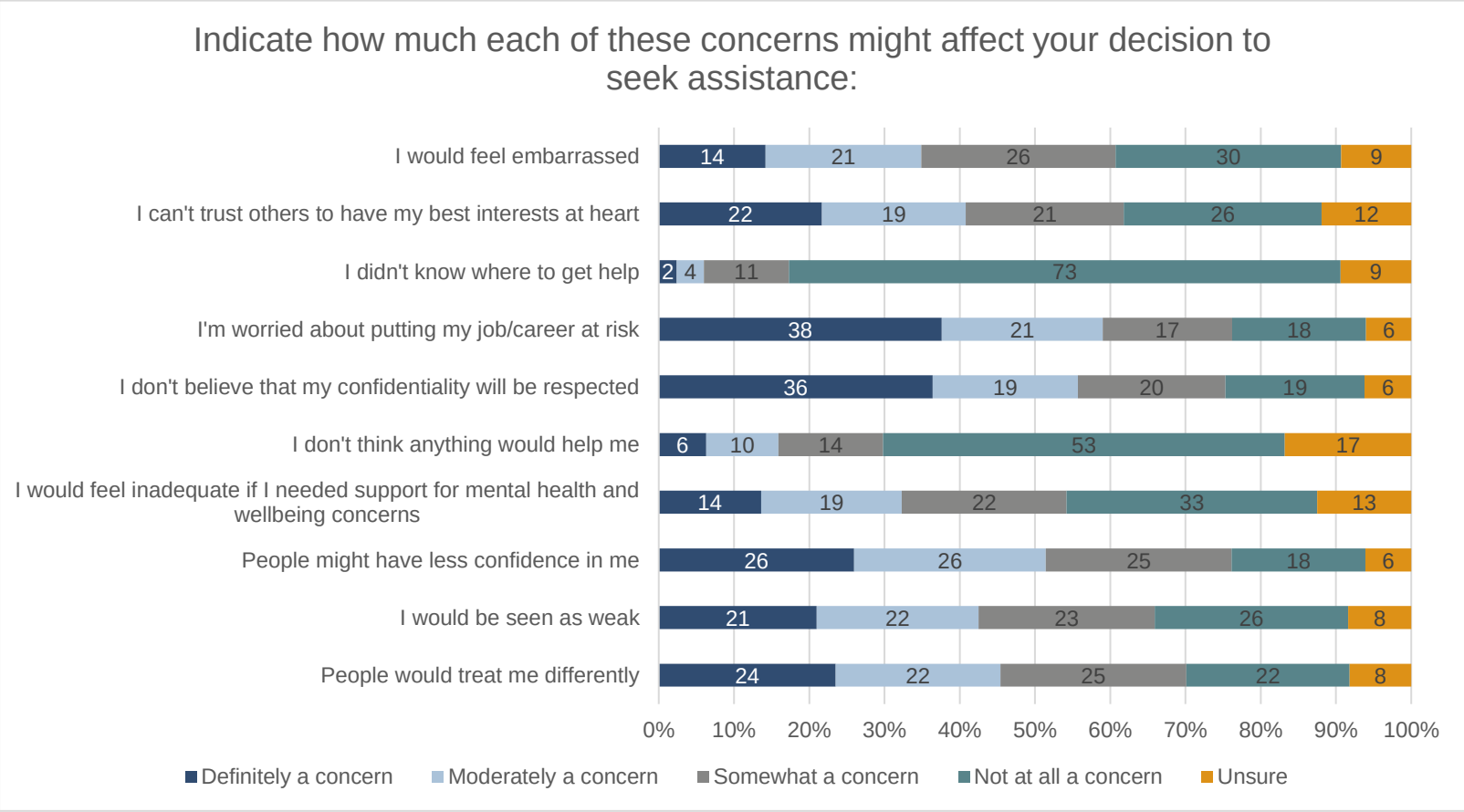
PSOs (N=122)



Support seeking preferences of PSO respondents (n=122)

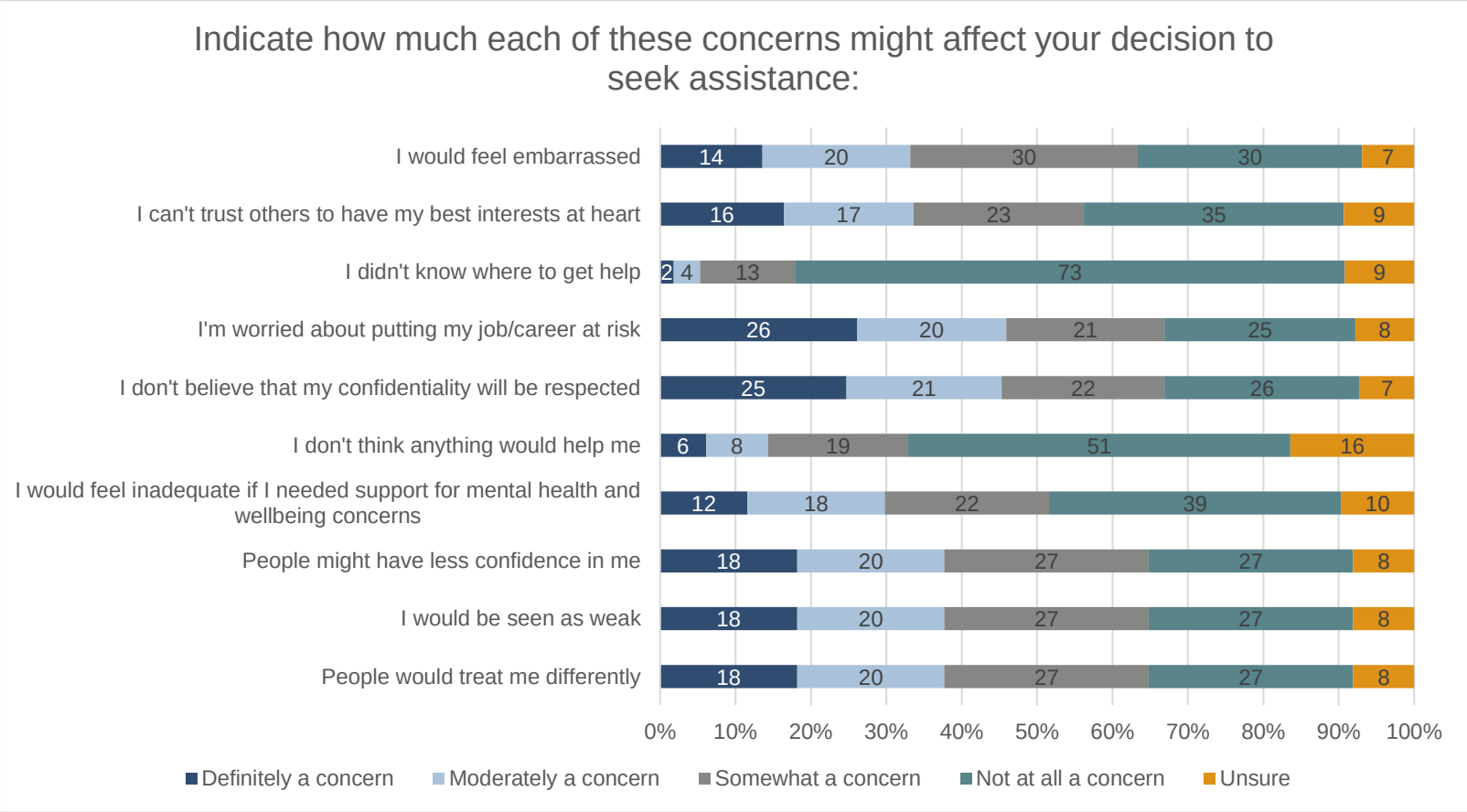
Appendix 0-7. Barriers to help seeking by role

Sworn members (N=1155)



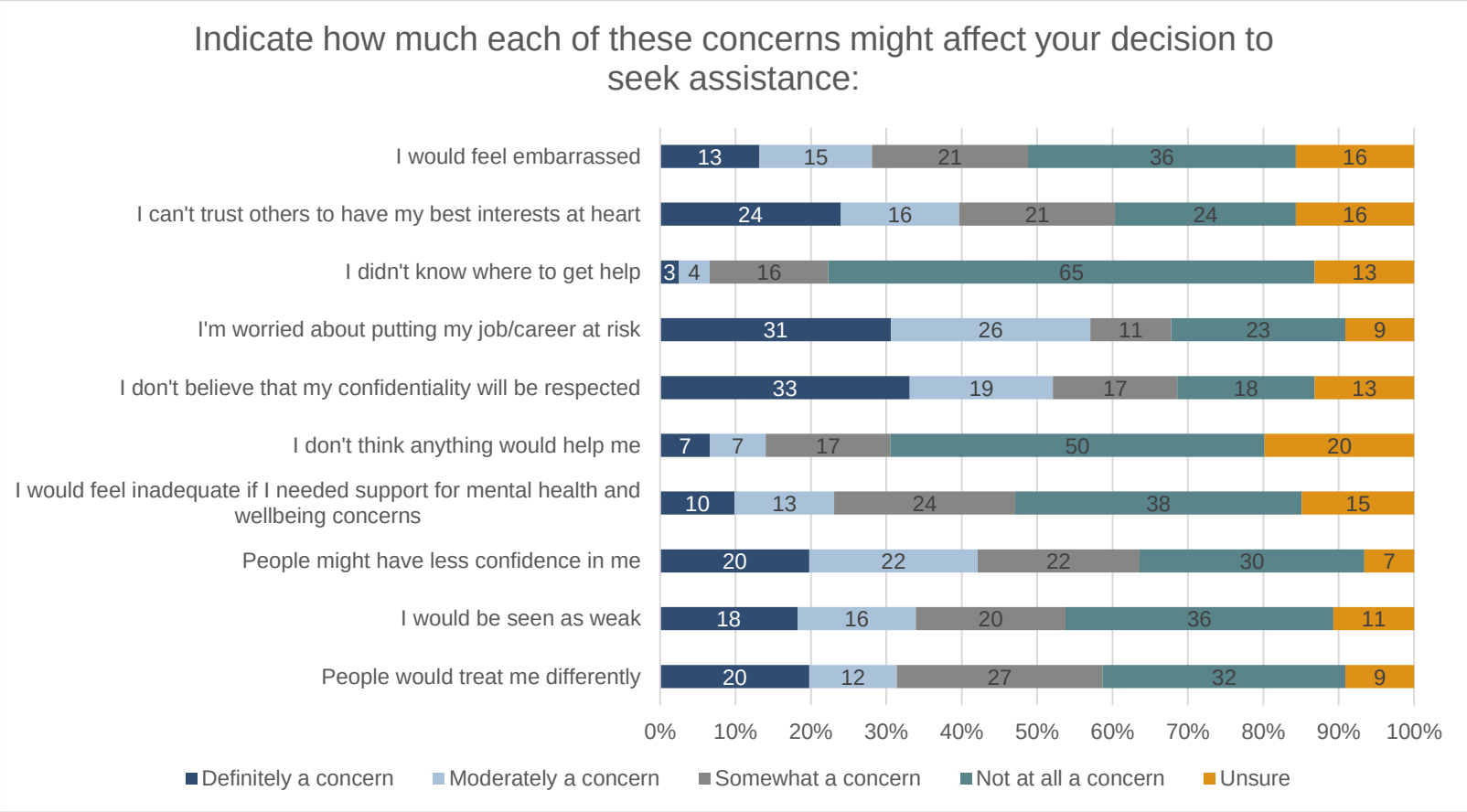
Perceptions of barriers to help seeking among sworn members (n=1155)

Unsworn / Professional staff (N=914)



Perceptions of barriers to help seeking among unsworn/professional staff (n=914)

PSOs (N=121)



Perceptions of barriers to help seeking among PSOs (n=121)

Appendix 0-8. Support service usage rates, and mean ratings of helpfulness and ease of access by demographics

	% of Respondents saying 'Yes' to using each service						
	Psych Services	**EAP**	**Chaplain**	**Confidant Network**	**Safe Place**	**Welfare Officers**	**External Provider**
Role							
Sworn	9%	4%	4%	3%	4%	4%	13%
Unsworn/Professional	8%	4%	3%	2%	4%	2%	15%
PSO	1%	1%	<1%	1%	1%	n<5	2%
Gender							
Male	10%	4%	4%	2%	3%	3%	14%
Female	7%	4%	3%	3%	5%	2%	15%
Other[1]	1%	<1%	n<5	n<5	<1%	n<5	1%
Age							
18 to 24	n<5	n<5	n<5	n<5	n<5	n<5	<1%

25 to 34	3%	2%	1%	1%	1%	1%	5%
35 to 44	6%	3%	2%	2%	3%	2%	10%
45 to 54	7%	3%	3%	1%	3%	2%	11%
55+	2%	1%	1%	1%	1%	1%	3%
Location							
ACT	11%	5%	4%	3%	5%	5%	18%
NSW	2%	1%	<1%	1%	1%	n<5	4%
NT	n<5	n<5	n<5	n<5	n<5	n<5	n<5
QLD	2%	1%	1%	n<5	1%	n<5	2%
SA	<1%	n<5	n<5	<1%	<1%	n<5	<1%
VIC & TAS	2%	1%	1%	1%	1%	n<5	4%
WA	1%	1%	1%	n<5	1%	n<5	1%
International[2]	<2%	n<5	<1%	n<5	n<5	n<5	<1%

[1] For this analysis the categories of 'indeterminate/intersex/unspecified' (n=12) and 'prefer not to say' (n=92) were combined into 'Other'.
[2] 'International' included international missions, international posts and external territories.

	Mean rating (out of 5) of helpfulness of each support service type						
	Psych Services	**EAP**	**Chaplain**	**Confidant Network**	**Safe Place**	**Welfare Officers**	**External Provider**
Distress							
Low (K10<25)	2.9	2.8	3.8	3.3	2.8	3.7	3.7
High (K10=>25)	2.5	2.2	3.6	2.1	2.3	3.6	3.7
Role							
Sworn	2.6	2.5	3.6	2.9	2.6	3.5	3.7
Unsworn/Professional	3.0	2.7	3.9	2.9	2.7	4.1	3.7
PSO	2.9	1.9	3.8	2.3	2.4	n<5	3.9
Gender							
Male	2.6	2.4	3.6	2.8	2.7	3.4	3.6
Female	3.0	2.7	3.9	2.9	2.6	4.0	3.7
Other[1]	3.0	1.8	n<5	n<5	2.3	n<5	4.1
Age							

18 to 24	n<5	n<5	n<5	n<5	n<5	n<5	4.3
25 to 34	2.9	2.5	2.9	2.5	2.5	3.4	3.5
35 to 44	2.7	2.5	3.9	2.9	2.4	3.4	3.7
45 to 54	2.8	2.5	3.6	2.9	2.9	3.9	3.7
55+	2.8	2.7	4.2	3.1	2.5	3.9	3.8
Location							
ACT	2.8	2.5	4.1	2.8	2.7	3.7	3.7
NSW	2.8	2.5	4.2	2.6	2.4	n<5	3.5
NT	n<5	n<5	n<5	n<5	n<5	n<5	n<5
QLD	2.9	2.4	3.2	n<5	2.7	n<5	3.6
SA	3.3	n<5	n<5	3.2	2.3	n<5	3.9
VIC & TAS	2.8	2.8	2.9	3.1	2.7	n<5	3.8
WA	2.5	2.8	3.2	n<5	2.3	n<5	3.8
International[2]	2.7	n<5	3.4	n<5	n<5	n<5	3.5

Higher scores indicate more favourable ratings.
[1] For this analysis the categories of 'indeterminate/intersex/unspecified' (n=12) and 'prefer not to say' (n=92) were combined into 'Other'.
[2] 'International' included international missions, international posts and external territories.

	Mean rating (out of 5) of ease of access for each support service type						
	Psych Services	**EAP**	**Chaplain**	**Confidant Network**	**Safe Place**	**Welfare Officers**	**External Provider**
Distress							
K10<25	3.2	3.6	4.0	3.8	3.7	3.9	3.8
K10=>25	2.8	3.0	3.6	3.1	3.2	4.0	3.8
Role							
Sworn	3.0	3.3	3.8	3.4	3.5	3.9	3.7
Unsworn/Professional	3.2	3.4	3.9	3.7	3.5	4.1	3.9
PSO	3.0	3.2	3.9	3.2	3.2	n<5	4.0
Gender							
Male	3.1	3.4	3.8	3.6	3.4	3.9	3.8
Female	3.1	3.3	3.9	3.4	3.6	4.0	3.8
Other[1]	3.3	2.8	n<5	n<5	3.3	n<5	4.0
Age							

18 to 24	n<5	n<5	n<5	n<5	n<5	n<5	4.4
25 to 34	3.0	3.3	3.5	3.4	3.6	3.5	3.9
35 to 44	3.1	3.3	3.9	3.3	3.3	3.9	3.8
45 to 54	3.1	3.5	3.8	3.7	3.7	4.3	3.8
55+	3.2	3.6	4.1	3.7	3.3	4.0	3.9
Location							
ACT	3.1	3.3	4.2	3.4	3.5	4.0	3.8
NSW	3.0	3.4	3.8	3.4	3.7	n<5	3.7
NT	n<5	n<5	n<5	n<5	n<5	n<5	n<5
QLD	3.3	3.6	3.3	n<5	3.6	n<5	3.9
SA	3.7	n<5	n<5	4.4	4.2	n<5	4.0
VIC & TAS	3.1	3.5	3.7	3.6	3.5	n<5	3.9
WA	2.7	3.7	2.9	n<5	3.4	n<5	3.9
International[2]	3.0	n<5	3.4	n<5	n<5	n<5	3.6

Higher scores indicate more favourable ratings.
[1] For this analysis the categories of 'indeterminate/intersex/unspecified' (n=12) and 'prefer not to say' (n=92) were combined into 'Other'.
[2] 'International' included international missions, international posts and external territories.

	Mean ratings of helpfulness for each type of support						
	Psych Services	**EAP**	**Chaplain**	**Confidant Network**	**Safe Place**	**Welfare Officers**	**External Provider**
Role							
Sworn	9%	4%	4%	3%	4%	4%	13%
Unsworn/Professional	8%	4%	3%	2%	4%	2%	15%
PSO	1%	1%	<1%	1%	1%	n<5	2%
Gender							
Male	10%	4%	4%	2%	3%	3%	14%
Female	7%	4%	3%	3%	5%	2%	15%
Other[1]	1%	<1%	n<5	n<5	<1%	n<5	1%
Age							
18 to 24	n<5	n<5	n<5	n<5	n<5	n<5	<1%
25 to 34	3%	2%	1%	1%	1%	1%	5%

35 to 44	6%	3%	2%	2%	3%	2%	10%
45 to 54	7%	3%	3%	2%	3%	2%	11%
55+	2%	1%	1%	1%	1%	1%	3%
Location							
ACT	11%	5%	4%	3%	5%	5%	18%
NSW	2%	1%	<1%	1%	1%	n<5	4%
NT	n<5	n<5	n<5	n<5	n<5	n<5	n<5
QLD	2%	1%	1%	n<5	1%	n<5	2%
SA	<1%	n<5	n<5	<1%	<1%	n<5	1%
VIC & TAS	2%	1%	1%	1%	1%	n<5	4%
WA	1%	1%	1%	n<5	1%	n<5	1%
International[2]	<1%	n<5	<1%	n<5	n<5	n<5	<1%

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Appendix 9: Template for the evaluation of implementation of the recommendations

Evaluation

A comprehensive evaluation framework is beyond the scope of this report but we offer the following template as a structure for the evaluation of implementation of the recommendations. The template provides a rating against four components: documentation, implementation, monitoring and evaluation, and outcomes, reflecting the stages of implementation.

Template for evaluating best practice

Component	Rating 1	2	3	4	5
Documentation and policy	No documentation or policy exists		Moderate quality documentation or policy; moderately well disseminated		High quality documentation or policy that everyone knows about
Implementation	Not done at all, no evidence of implementation		Sometimes done, inconsistent implementation or quality		Always done and/or good quality
Monitoring and Evaluation	No evidence of recording, monitoring or evaluation		Sometimes monitored in terms of compliances, some evaluation of value		Routine monitoring of compliance, standard evaluations routinely completed
Outcomes	No evidence of any benefit arising (or not implemented at all)		Some evidence of positive outcomes, moderate feedback		Clearly beneficial outcomes, strong positive feedback

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